



Printable Donation Form

Title: _____ First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Email: _____

This donation is made by: an Individual a Business _____
Company Name

GIFT AMOUNT:

Yes, I'd like to support St. Michael's Hospital Foundation with my gift of \$ _____

Your donation will support the highest priority needs of the hospital. **Thank you!**

PAYMENT METHOD:

Cheque made payable to St. Michael's Hospital Foundation

VISA MASTERCARD AMERICAN EXPRESS

Credit Card Information:

Credit Card Number:

Expiry Date: /

Name on Card: _____

Email: _____

Signature: _____

Yes, sign me up to receive e-newsletters.

Yes, I'd like to receive my tax receipt by email. _____

Tax receipts are issued for gifts of \$20 or more.

Please return completed form via email to hello@stmichaelsfoundation.com, or mail to 30 Bond St, Toronto, ON M5B 1W8.

To make a donation by phone, please call 416 864 5000. Charitable Registration #122963663RR0001

Thank you for supporting St. Michael's Hospital Foundation.