MONTHLY DONATION FORM

Title: ____ **First Name:** _____ **Middle Initial:** ___ **Last Name:** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Telephone: _____ **Email:** _____

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

GIFT AMOUNT:

Yes, I'd like to support St. Michael's Foundation with my monthly 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

___ Please debit my bank account. My cheque marked VOID is enclosed.

___ 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. _____

A consolidated tax receipt will be mailed in February for all monthly donations made in the previous calendar year.

Please return completed form via email to **connect@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 and Providence Healthcare.