PROVIDENCE
HEALTHCARE FOUNDATION

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 Providence Healthcare 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 Providence Healthcare 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 **hello@phcf.ca**, or mail to 3276 St Clair Ave E, Scarborough, ON M1L 1W1.
To make a donation by phone, please call 416 285 3800. Charitable Registration #122963663RR0001

Thank you for supporting Providence Healthcare Foundation.