PROVIDENCE
HEALTHCARE FOUNDATION

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 Providence Healthcare 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@phcf.ca**, or mail to 3276 St. Clair Avenue East, 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.