HOSPICE ORILLIA
MONTHLY GIVING DONATION FORM

DONOR INFORMATION

Donor Name *(Title/First Name/Last Name)*: _____

Street Address: _____

City/Town:_____ Province:_____ Postal Code: _____

Telephone:_____ E-mail Address: _____

☐ I wish to receive Hospice Orillia newsletter and other communications *(please complete email address).*

MONTHLY DONATION

Once a month I wish to give:

☐ $10 ☐ $25 ☐ $50 ☐ Other: $_____per month

I authorize Hospice Orillia to withdraw the above amount from my bank account on the 15th day of every month. I may change the amount or cancel my monthly contribution at any time by notifying Hospice Orillia.

Donor Signature:_____ Date:_____

Please enclose a cheque, with VOID written across it, for Hospice Orillia to arrange automatic withdrawal from your bank account, or provide the following account information:

Institution Number: _____

Transit Number: _____

Bank Account Number: _____

A charitable tax receipt will be issued and sent by mail in January of the following year.

THANK YOU FOR YOUR SUPPORT – PLEASE MAIL OR FAX DONATION FORM TO:

MAIL: Hospice Orillia, 169 Front Street South, Orillia, ON L3V 4S8 **FAX:** 705 325 7328

If you have any questions, please contact us at (705) 325-0505.

Privacy Policy: Hospice Orillia respects your privacy and will not sell or distribute your personal information to anyone. The information you provided us will only be used to contact you regarding your donation or to keep you informed of our activities.

Charitable Business Number: 135837748RR0001