Comfort, Care & Hope Monthly Giving Program

YES, I will join the Comfort, Care & Hope Monthly Giving Program and help Hotel Dieu Shaver Foundation fund patient-care equipment, specialty clinics, and improvements to treatment areas to support exemplary patient care at Hotel Dieu Shaver.

NAME: _____
(required for receipt purposes)

HOME ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

EMAIL: _____ PHONE: _____

GIFT AMOUNT:

- ☐ $10 /MONTH ($120 per year)
- ☐ $15 /MONTH ($180 per year)
- ☐ $25 /MONTH ($300 per year)
- ☐ $35 /MONTH ($420 per year)
- ☐ $50 /MONTH ($600 per year)
- ☐ Other Amount $_____ /MONTH

One Payment of $_____

OPTION #1: AUTOMATIC BANK TRANSFER

I authorize HDS Foundation to receive the above amount from my bank account on or about the 15th day of each month. My sample cheque marked "VOID" is enclosed.

Signature: _____ Date: _____

OPTION #2: CREDIT CARD PAYMENT

☐ VISA ☐ Mastercard ☐ American Express

CC#: _____ Expiry Date: _____

Signature: _____

OPTION #3: CHEQUE

☐ Post-dated cheques for the year are enclosed.

DESIGNATION

Please designate my gift to the following area:

- ☐ Most Urgent Needs
- ☐ Nursing Unit Needs
- ☐ Parkinson's Centre for Rehab
- ☐ Rehabilitation Needs
- ☐ Cancer Rehab Program
- ☐ Other: _____

Please note all donation information is treated as confidential.

- ☐ My gift may be recognized in printed material
- ☐ Please ensure that my gift remains anonymous
- ☐ Please send me information on how I can leave a gift in my will and other gift planning options.

THANK YOU for becoming a member of the Comfort, Care & Hope Monthly Giving Program.

Please Note: You may alter or cancel your donation at any time by contacting HDS Foundation.
For questions & inquiries contact HDS Foundation at hdsfoundation@hoteldieushaver.org or 905-685-1381 ex.84214