

# Donation Form Page 1



## Donor Information

Title:  (Mr., Miss, Ms., Mrs. Dr.)  
First Name:  Initial(s):  Last Name(s):   
Street Address:   
City:  Province:  Postal Code:   
Telephone Number:  Fax Number:   
Home Email:  Business Email:

## Gift Information

Total Gift Amount: \$

One time       Recurring Monthly donation

## Recognition Information

**OR**       Anonymous

*Please enter name as how you would like it to appear on all recognition material*

## Payment Information

Cheque - Please make your cheque payable to the *Cambridge Memorial Hospital Foundation*.

Visa       MasterCard       Amex

Card Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_

Void cheque attached for Electronic Funds Transfer (Monthly donation)

## Please return to:

### **Cambridge Memorial Hospital Foundation**

700 Coronation Boulevard  
Cambridge, ON N1R 3G2

Tel: (519) 740-4966

Fax: (519) 740-4971

[www.cmhfoundation.ca](http://www.cmhfoundation.ca)

*Charitable Registration: 11882 6288 RR0001*

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Thank you for your generous support!

**PAGE 2 - Additional Information for sending notifications:**

The above donation is given  In Memory  In Honour  
of the following person:

**Please notify this person that a gift was made:** (gift amount will not be shared)

Name(s):  Company   
Street Address:   
City:  Province:  Postal Code:

**Special Instructions or Comments**

**Please return both pages to:**

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