CaringGIFTS

Together, we make it possible.

Donor Information

Title ☐ Dr. ☐ Mr. ☐ Miss. ☐ Ms. ☐ Mrs. First ______ Last Name ______

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City ______ Province ______ Postal Code ______

Telephone ______ Home Email ______

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Gift Information

Total Gift Amount ______ Gift over (# of years) ______

Payments to Begin______ Frequecy (monthy or annually)______

Legacy Gifts

☐ I have included CMH in my will

☐ I wish to learn more about leaving a gift in my will

Recognition Information

☐ I wish my gift to remain 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**

☐ Void cheque attached for Monthly Electronic Funds Transfer

☐ Visa ☐ MasterCard ☐ AMEX

Card Number ______ Expiry Date______

Signature ______ Date______

PLEASE RETURN TO:
Cambridge Memorial Hospital Foundation
700 Coronation Blvd.
Cambridge, ON N1R 3G2

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F: 519-740-4971
E: foundation@cmh.org

www.cmhfoundation.ca

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THANK YOU FOR YOUR GENEROUS SUPPORT!

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