

# Donation Form (Please print)

Date: \_\_\_\_\_  
 Donation Amount: \$ \_\_\_\_\_ Salutation: Mr. Mrs. Ms. Miss  
 Donor Name: \_\_\_\_\_  
 (Individual or Organization)  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Monthly Donations:** Yes, I'd like to make a monthly commitment to the Calgary Health Trust and its vision. I authorize the Calgary Health Trust to receive: \$ \_\_\_\_\_ each month.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I prefer to make my monthly gift by credit card. (Please complete credit card information below)
- Please debit my bank account. (A sample cheque marked VOID is enclosed)

Our guarantee: You can change or cancel your monthly donation at any time by contacting us at (403) 943-0615.

I may revoke my authorization at any time, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca). "I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca)."

### Tribute Donation

(Circle One) Yes No

In Memory / In Honour of: \_\_\_\_\_  
 Honouree Occasion: \_\_\_\_\_  
 Next of Kin / Honouree info: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Next of Kin Relationship to Deceased: \_\_\_\_\_

### Direct Donation To

Are you responding to a package received in the mail?  
 (Circle One) Yes No

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Calgary Health Trust Annual Fund for Greatest Needs | <input type="checkbox"/> Rockyview General Hospital:          | <input type="checkbox"/> Peter Lougheed Centre:         |
| <input type="checkbox"/> Foothills Medical Centre:                           | <input type="checkbox"/> Greatest Needs                       | <input type="checkbox"/> Greatest Needs                 |
| <input type="checkbox"/> Greatest Needs                                      | <input type="checkbox"/> Staff Education                      | <input type="checkbox"/> Staff Education                |
| <input type="checkbox"/> Staff Education                                     | <input type="checkbox"/> Unit / Program Greatest Needs:       | <input type="checkbox"/> Unit / Program Greatest Needs: |
| <input type="checkbox"/> Unit / Program Greatest Needs:                      |   |   |
| _____  | _____   | _____   |
| <input type="checkbox"/> Carewest:   | <input type="checkbox"/> Women's Health:                      | <input type="checkbox"/> Other                          |
| <input type="checkbox"/> Greatest Needs                                      | <input type="checkbox"/> Greatest Needs                       | _____   |
| <input type="checkbox"/> Staff Education                                     | <input type="checkbox"/> Staff Education                      |   |
| <input type="checkbox"/> Site/Program: _____                                 | <input type="checkbox"/> Unit / Program Greatest Needs: _____ |   |

**Calgary Health Trust**  
 800-11012 Macleod Trail SE Calgary, AB T2J 6A5  
 Phone: (403) 943-0615 Fax: (403) 943-0628 [www.thetrust.ca](http://www.thetrust.ca)

### Credit Card Information

Visa  MasterCard  American Express

Name on Credit Card: \_\_\_\_\_  
 Credit Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_  
 Signature: \_\_\_\_\_