Clinton Public Hospital Foundation
Donation Form

Amount of Contribution

I wish to make a tax-deductible contribution of:

___$5,000 ___ $1,000 ___ $500 ___ $250 ___ $100 ___ $50 ___ Other - $_____

_____ This gift is a Memorial Donation _____ This gift is a Tribute Gift. .

In order that the Foundation can send an acknowledgement, please provide the name & address of bereaved family **or** person(s) being honoured with a Tribute Gift._____

_____ This gift is a "Thankful Patient" Gift

In order that the Foundation can send an acknowledgment, please provide the name of the health care individual(s) you wish to personally thank. _____

_____ I wish to have my gift remain anonymous

Method of Payment

_____Cheque _____VISA _____MasterCard

Please make cheques payable to *Clinton Public Hospital Foundation*

Card # _____ **Expiration Date** _____/_____

Name on Card _____

Signature _____

Donor Information

Name _____

Address _____ **City** _____

Province_____ **Postal Code** _____ **Phone # ( )**_____

Preferred E-mail (optional) _____

Please mail, drop off or fax the completed Donation Form to:

Clinton Public Hospital Foundation
98 Shipley Street
Clinton, Ontario N0M 1L0
Fax: 519-482-5960

Thank you kindly for your support!

Charitable Registration Number ~ 89096 0685 RR0001

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