

DONATION FORM



CONTACT INFORMATION

First Name

Last Name

Preferred Name

Spouse / Partner :

Full Address :

City / Country :

Postal Code :

Phone Number :

E-Mail :

GIFT INFORMATION

I would like to make a gift of :

\$

One Time Gift :

Monthly :

I'd like to pay by:

Cheque (Enclosed)

Visa

Mastercard

Amex

Name of Cardholder :

Card Number

Expiry

D

D

/

Y

Y

Cardholder Signature

This space is where you can share information on the designation of your gift.

Charitable Receipt will be issued for all donations

Please return this form either in person or by mail to:

Lions Gate Hospital Foundation

231 15th Street E. North Vancouver, BC V7L 2L7

THANK YOU FOR YOUR SUPPORT