North Bay Regional Health Centre Foundation
Fondation du Centre régional de santé de North Bay

Donation/Pledge Card

Personal Info

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ E-Mail: _____

I/we wish to contribute

A) a total gift of $_____ payable over ☐1 yr ☐ 2 yrs ☐ 3 yrs ☐ Monthly Program

- with payments made: ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly ☐ Other_____

- with payments starting on: _____/_____/_____
(day / month / year)

- payable by: ☐ postdated cheques ☐ pre-authorized transfer ☐ To mail cheque upon reminder
(include a void cheque)
☐ Visa ☐ MasterCard
Credit Card No. _____ Expiry date: _____

Please designate my gift to: ❍ the Greatest Need Fund ❍ Other_____

❍ I would like my name to appear as _____
on published donor recognition lists.

_____ _____
Date Signature

❍ As an inspiration to others, I agree to allow my name to be added to the Foundation donor list and donor wall.
OR
❍ I wish my name to remain anonymous. *(Your name will not be added to any donor list).*

Gift in honour of _____

❍ Birthday ❍ Anniversary ❍ Tribute ❍ Other_____

Please indicate name and address to send honourary acknowledgement

_____

_____

Enhancing your healthcare, close to home.

North Bay Regional Health Centre Foundation
50 College Drive, P.O. Box 2500 North Bay ON P1B 5A4
PHONE: 705-495-8125 FAX: 705-495-8121

CHARITABLE NO. BN 88773 1123 RR0001

- Please return this form with your donation
- Please write any additional comments or notes on the reverse side
- Please include postdated cheques or void cheque if applicable