

DONATION FORM

Please complete this form and return to:
220 - 71 Mearns Ct. Bowmanville, ON L1C 4N4
T: 905-623-3331 x 21881 E: bhfoundation@lh.ca



First Name: _____ Last Name: _____ Spouse Name: _____

Organization (if applicable): _____

Address: _____

City: _____ Province: _____ Postal Code: _____ Country: _____

Phone (Day): _____ Phone (Alternate): _____ Email: _____

Where would you like to designate your gift?

Redevelopment & Expansion Project Other (please indicate designation) _____

This gift is in honour of/in memory of/in celebration of (person's name): _____

Would you like us to send notification to the Next of Kin or Honouree? Yes No

If yes, please provide Complete Name & Address of Next of Kin/Honouree (If unable to provide information for Next of Kin, please name funeral home of service)

First Name: _____ Last Name: _____ Funeral Home: _____

Address: _____

City: _____ Province: _____ Postal Code: _____ Country: _____

PAYMENT INFORMATION

One-time Payment Monthly

Gift Amount \$ _____ Preferred Process Date: _____

Card Type: VISA MasterCard American Express Cheque

Card Number: _____ Expiry Date: _____ CVV: _____

Signature: _____

Date: _____

Privacy Policy: Bowmanville Hospital Foundation is strongly committed to protecting the privacy and confidentiality of your personal information. We value your trust and recognize that maintaining this trust requires that we be open and accountable in our treatment of the personal information that you choose to share with us. We do not lend, rent or sell your information. Personal information collected by the Foundation is kept in strict confidence.

THANK YOU

Charitable Registration No. 11924 4903 RR0001