MONTHLY GIVING DONATION FORM

DONOR NAME:		CONSTITUENT ID#	
ADDRESS (number, street name)			
CITY	PROVINCE	POSTAL CODE	PHONE NUMBER:

PAYMENT METHOD:

- ☐ VISA
- ☐ MASTERCARD
- ☐ AMERICAN EXPRESS
- ☐ CHEQUE

CREDIT CARD INFORMATION:

Credit Card Number:

Cardholder's Name:

Expiry Date: CVV:

Please make cheque payable to:
St. Michael's Hospital Foundation

MONTHLY AMOUNT:

$

- ☐ AREAS MOST NEEDED
- ☐ DESIGNATION:

NAME OF STAFF:

DATE:

COMMENTS:

☐ **PLEASE DO NOT MAIL ME ANY FUTURE CORRESPONDENCE**