

# MAIL-IN DONATION FORM

South Muskoka Hospital Foundation  
75 Ann Street  
Bracebridge, ON P1L 2E4  
Tel: (705) 645-4404 ext. 3193  
Fax: (705) 645-0352



Mr.       Mrs.       Ms       Dr.       Other: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address 1: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
City/Town: \_\_\_\_\_ Province: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_ Email: \_\_\_\_\_

<p><b>YES</b>, I would like to make a donation of:</p> <p><input type="checkbox"/> \$25      <input type="checkbox"/> \$50      <input type="checkbox"/> \$75      <input type="checkbox"/> \$100      <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Visa      <input type="checkbox"/> MasterCard      <input type="checkbox"/> Amex      Expiry: _____ / _____</p> <p>Card #: _____</p> <p>Name on card: _____ Signature: _____</p> <p><input type="checkbox"/> I am interested in becoming a monthly donor. Please contact me.</p>
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If your gift is in memory or honour of someone, please let us know the following:

In honour       In memory  
Name: \_\_\_\_\_

Please send an acknowledgement card to:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Thank you for making a difference!  
An official receipt will be issued for income tax purposes.  
Charitable Business No. 119157998 RR0001.