Raising funds. Raising hope.

SWEB

Name: _____

Address: _____

City/Prov./Postal Code: _____

Telephone: _____

E-mail: _____

O **I have a new address**

Thank you for supporting The Children's.

I would like to donate:

O $35 O $50 O $75 O $100 O Other: $ _____

OR

I authorize the MCHF to deduct, once a month, the amount of:

O $10 O $15 O $20 O Other: $ _____

Big care for little kids

Please designate my gift to...

O The Hospital's most urgent needs

O Other: _____

Method of payment

O Cheque(s) Please make cheques payable to The Montreal Children's Hospital Foundation.

O Mastercard O VISA O AMEX

Card number

M	M	Y	Y

Expiry date

_____

Signature

OR

O I would like to give monthly through my bank account
(Please enclose a cheque marked "void" for automatic bank withdrawals.)

Terms and conditions of the Monthly Giving Program. I agree to the following Terms and Conditions:
- We warrant and garantee that all persons whose signature is required to authorize withdrawals from the Account have signed the Authorization below.
- We may cancel this Authorization at any time upon providing written notice to The Montreal Children's Hospital Foundation.
- We have read and understood the terms of participating in The Montreal Children's Hospital Foundation Monthly Donor Giving Program.

_____

Signature

OR

O Gift of securities (public). (A Foundation employee will contact you.)

I would like to learn more about...

O Monthly giving O Gift planning
O Gifts in honour/in memory O Gifts of securities (public)

O I wish to remain anonymous
O Je préfère recevoir ma correspondance en français

The Montreal Children's Hospital Foundation

children foundation.com

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