

I Wish to Support The



Please find enclosed, my donation for \$ _____ Receipt for tax purposes

No Receipt

Name: _____ Phone: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Email: _____

I wish to contribute: Weekly Monthly Annually

Bequests / large gifts (please have a Foundation Rep call me)

I wish to contribute by: Cheque Credit Card Type of Card: _____

Card #: _____ Expiry Date: _____

Name (on card): _____ Signature: _____

Comments / Suggestions: _____

I wish support for my contribution(s) allocated towards:

All Foundation programs

Community Care Northumberland

Port Hope Walk-In clinic

Training / Bursaries

Community Healthcare equipment

Pool Therapy Programs

Please Mail To:

Port Hope & District Healthcare Foundation

P.O. Box 235, Port Hope, ON, L1A 3W3