

**Yes! I would like to help the Carleton Place & District Memorial Hospital provide the best possible healthcare to Carleton Place & the surrounding communities.**

**Step One: Gift Amount and Frequency (*Donations of \$500 or more will be recognized on our Donor Wall*)**

I am pleased to donate the following amount each month:

- |  |   |
|--|---|
| <input type="checkbox"/> \$10.00 (\$120/year)                      | <input type="checkbox"/> \$25.00 (\$300/year)   |
| <input type="checkbox"/> \$50.00 (\$600/year)                      | <input type="checkbox"/> \$75.00 (\$900/year)   |
| <input type="checkbox"/> \$100.00 (\$1200/year)                    | <input type="checkbox"/> \$150.00 (\$1800/year) |
| <input type="checkbox"/> \$200.00 (\$2400/year)                    | <input type="checkbox"/> \$250.00 (\$3000/year) |
| <input type="checkbox"/> Other (please indicate the amount)\$_____ |   |

OR I prefer to give once a year. Enclosed is my donation of \$ \_\_\_\_\_

**Step Two: I would like to direct my gift to:**

- new equipment
- the Compassionate Caregiver Program in honour of \_\_\_\_\_
- the memory of \_\_\_\_\_
- construction of new hospital
- staff education
- where the need is greatest

**Step Three: Method of Payment**

- Enclosed is my cheque/money order for a one time gift (payable to the Carleton Place & District Memorial Hospital Foundation.)
- I have included post dated cheques for my monthly donations
- I authorize the CPDMH Foundation to receive the above amount from my bank account on or about the 15<sup>th</sup> of each month. My sample cheque marked "Void" is enclosed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Please charge my credit card in the schedule indicated above on or about the 15<sup>th</sup> of each month.
  - VISA       MasterCard

Card #: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Step Four: Contact Information for Receipting Purposes (*All contact information will remain private. The CPDMH Foundation does not share or sell its donor information*)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

- I have included a gift to the Carleton Place & District Memorial Hospital Foundation in my will.
- I would like information on how to leave a gift to the Carleton Place & District Memorial Hospital in my will.

**Completed forms should be returned to:**

Carleton Place & District Memorial Hospital Foundation  
211 Lake Ave East - Carleton Place, On - K7C 1J4  
Ph (613) 257-2200 x 856 - Fax: (613) 257-5197 - E-mail [ctroy@carletonplacehosp.com](mailto:ctroy@carletonplacehosp.com)  
Charitable Registration Number: 86610 5398 RR0001

**Thank you for taking the time to make a difference!**