# Donation Form (Please print)

Calgary Health Trust

Date: _____
Donation Amount: $_____ Salutation: □Mr. □Mrs. □Ms. □Miss
Donor Name: _____
(Individual or Organization)
Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone: _____ E-Mail:_____

**Monthly Donations:** Yes, I'd like to make a monthly commitment to the Calgary Health Trust and its vision. I authorize the Calgary Health Trust to receive: $_____ each month.

Signature: _____Date:_____
□ I prefer to make my monthly gift by credit card. (Please complete credit card information below)
□ Please debit my bank account. (A sample cheque marked VOID is enclosed)
Our guarantee: You can change or cancel your monthly donation at any time by contacting us at (403) 943-0615.

I may revoke my authorization at any time, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca. "I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

## Tribute Donation (Circle One) Yes No

In Memory / In Honour of: _____
Honouree Occasion: _____
Next of Kin / Honouree info: _____
Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone: _____ E-Mail:_____
Next of Kin Relationship to Deceased: _____

## Direct Donation To

Are you responding to a package received in the mail?
(Circle One) Yes No

□ Calgary Health Trust Annual Fund for Greatest Needs (TRGN001)

□ Foothills Medical Centre:
- ☐ Greatest Needs
- ☐ Staff Education
- ☐ Unit / Program Greatest Needs: _____

□ Rockyview General Hospital:
- ☐ Greatest Needs
- ☐ Staff Education
- ☐ Unit / Program Greatest Needs: _____

□ Peter Lougheed Centre:
- ☐ Greatest Needs
- ☐ Staff Education
- ☐ Unit / Program Greatest Needs: _____

□ Primary Care Networks (PCN) _____ □ Other_____

□ Carewest:
- ☐ Greatest Needs
- ☐ Staff Education
- ☐ Site/Program: _____

□ Women's Health:
- ☐ Greatest Needs
- ☐ Staff Education
- ☐ Unit / Program Greatest Needs: _____

□ South Health Campus
- ☐ Greatest Needs
- ☐ Staff Education
- ☐ Unit/Program_____

**Calgary Health Trust**
**800-11012 Macleod Trail SE Calgary, AB T2J 6A5**
**Phone: (403) 943-0615 Fax: (403) 943-0628 www.thetrust.ca**

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Credit Card Information
□Visa □MasterCard □American Express
Name on Credit Card:_____
Credit Card Number: _____ Expiry Date:_____
Signature: _____