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# DONATION FORM

Please complete the information below.

## PLEDGE TYPE

Monthly  One time Are you a current monthly donor?  Yes  No

## PERSONAL INFORMATION

Title:  Mr.  Mrs.  Miss  Ms.  Dr.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Will today's donation be made on behalf of a business?  Yes  No

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

Primary contact:

Title:  Mr.  Mrs.  Miss  Ms.  Dr.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

## ADDRESS INFORMATION

Suite/Office/Floor/Apt. No: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ ext: \_\_\_\_\_

Alt. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## DONATION INFORMATION

Donation Amount: \_\_\_\_\_ Payment Method:  Credit Card  Cash  Cheque\*

VISA  MasterCard Credit Card Number: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_ \*Expiry: \_\_\_\_/\_\_\_\_

Name on Credit Card: \_\_\_\_\_ CVC: \_\_\_\_\_ (3 digit security code on back of card)

(\*Make cheques payable to Stollery Children's Hospital Foundation)

## OTHER INFORMATION

What led you to donate today?  General  Direct Mail  Radio Broadcast  Advertising  Other

Is this a tribute gift?  In Honour Of  In Memory of\* Name: \_\_\_\_\_

\*Please provide next of kin contact information for memorial gifts

Title:  Mr.  Mrs.  Miss  Ms.  Dr.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Suite/Office/Floor/Apt. No: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ ext: \_\_\_\_\_

The Stollery Children's Hospital Foundation issues tax receipts for gifts \$25 or more, or upon request. Monthly donations are receipted annually.

**THANK YOU FOR DONATING TO THE STOLLERY CHILDREN'S HOSPITAL FOUNDATION!**