



## 'Picture of Health' Campaign Pledge Form

I/we would like to make a pledge with a total contribution of \$\_\_\_\_\_.

### **My Contact Information:**

Mr.  Mrs.  Ms.  Dr. Name (please print): \_\_\_\_\_

Street Address: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email address: \_\_\_\_\_

Business Telephone: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

### **My/Our Pledge:**

I wish to make a one-time donation of \$ \_\_\_\_\_

I wish to make an annual donation of \$ \_\_\_\_\_ for  1 year  2 years  3 years  4 years  5 years

I wish to make monthly installments of \$ \_\_\_\_\_ for  1 year  2 years  3 years  4 years  5 years

Pledge installments will begin on \_\_\_\_\_ (date)

### **My Payment Preference:**

Cheque payable to the Almonte General Hospital – Fairview Manor Foundation is enclosed.

Post-dated Cheque(s) are enclosed  Monthly withdrawals from my Bank (void cheque enclosed)

I wish to make a donation of shares. Please contact me regarding details.

VISA  MasterCard Card # \_\_\_\_\_ Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_

### **My Recognition:**

Unless you choose to remain anonymous, donations of \$5,000 or more will be acknowledged.

I wish for my/our contribution to remain anonymous.

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