Lake of the Woods District Hospital Foundation
21 Sylvan Street West, Kenora, ON P9N 3W7
Tel: (807) 468-9861 Ext. 2469 Fax: (807) 468-6051

Monthly Donation Form

Please provide the following information:

Donor First Name: ______________________ Last Name: ______________________

Company Name: ____

Street Address: ____

City: ____

Province: ______________________ Postal Code: ______________________

Phone: ____

Email: ____

Please direct my donation to: ☐ Area of Greatest Need ☐ Other:______________________

I would like to make:

☐ A **monthly gift** in the amount of: ☐$100 ☐$50 ☐$35 ☐$25 ☐$10 ☐ Other $_______
(CDN Funds)

Select one: ☐ For **#** ______ months ☐ Until I reach **$**________ ☐ Until I notify you

Payment Method: ☐ VISA ☐ MasterCard ☐ **VOID** cheque for Electronic Funds Transfer (EFT)

Card Number: ______________________________________ Expiry Date: ______________

Name on Card: ______________________ Authorized Signature: ______________________

All cheques may be made payable to Lake of the Woods District Hospital Foundation

Please note: Your donation amount will be charged to your credit card on the 16th day of every month; or via EFT from your bank account on the 25th day of every month.
You will receive your tax receipt in January of next year.

Please send donation to: Lake of the Woods District Hospital Foundation
21 Sylvan Street West, Kenora, ON P9N 3W7 Canada

Charitable Registration (BN) 13710 5243 RR0001
A receipt will be issued for donations of $10 or more. Our donor records are confidential; we do not share, rent or sell our lists.
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