



**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

# Pledge 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 **financial pledge** in the amount of:  \$10,000  \$5,000  \$1,000  \$500  Other \$ \_\_\_\_\_  
(CDN Funds)

**Select one:**  To be completed by payments of \$ \_\_\_\_\_ over the course of (#) \_\_\_\_\_ of months/years

My payment will be \$ \_\_\_\_\_ every (#) \_\_\_\_\_ weeks/months/years

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*

***By signing, I acknowledge my commitment and confirm that my pledge will be completed as above.***

**Donor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Received at LWDHF by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please note:** Your donation amount will be charged to your credit card on the 16<sup>th</sup> day of every month; or via EFT from your bank account on the 25<sup>th</sup> 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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