

Partners in Care Monthly Giving Plan

YES, I want to join the *Partners in Care monthly giving plan*. Each month, I want to give the amount of:

\$5 \$10 \$15 \$20 \$30 (\$1/day) I prefer to give \$_____ per month.

Name _____

Telephone _____ E-mail _____

Signature _____ Date _____

Option 1:

I authorize The Ottawa Hospital Foundation to draw these donations from my bank account. My sample cheque marked "void" is enclosed.

Option 2:

Charge these donations to my: VISA MasterCard American Express

Card No. _____ Expiry Date _____

Cardholder's Name _____

Please note that you will receive only one tax receipt for the full amount of your monthly donations at the end of the year.