



Yes,

I want to enhance the care of the 200 residents and their families who call Mount St. Mary Hospital home.

My Gift:

☐ Please accept my **one-time donation** of: \$ _____

OR

☐ Please accept my **monthly* donation** of:

☐ \$15/mo

☐ \$25/mo

☐ \$55/mo

☐ \$100/mo

☐ Other \$ _____

* Monthly Giving: I understand that payments will continue automatically each month until I notify Mount St. Mary Hospital of any changes by calling 250-480-3138. I understand that I can change or cancel my monthly donation at any time, and I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Pre- Authorized Debit agreement. I have certain recourse rights if any debit does not comply with this agreement, and to obtain more information on my recourse rights, I may contact my financial institution or visit cdnpay.ca.

Deducted on the ☐ 1st of the month ☐ 15th of the month

My Area of Interest:

☐ Area of Greatest Need

☐ Specialized Equipment

☐ Room Renovations

☐ Resident Programs

☐ Pastoral Care

☐ Sisters of St. Ann Legacy Fund

My Information:

☐ I would like
to remain
anonymous

☐ Cheque ☐ Credit Card ☐ Electronic Funds Transfer

Name _____

Credit Card # _____

Expiry _____

Address _____

Signature _____

City _____

Prov _____

Postal Code _____

Phone _____

Email _____

For an electronic funds transfer please attach a VOID cheque or banking information from your financial institution.

Thank you for supporting the residents of Mount St. Mary Hospital.

861 Fairfield Rd Victoria BC V8V 5A9 | 250-480-3138 | mountstmary.ca | Charitable registration #11904 8205 RR0001