Soldiers' MEMORIAL HOSPITAL Orillia

Employee Giving Program
DONATION FORM

Employee Information

Name: _____

Address: _____

_____
City *Province* *Postal Code*

Email: _____ Phone: _____

Donation Details

☐ *Yes, I would like to participate in the Soldiers' Employee Giving Program by contributing:*

$ _____ ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Yearly ☐ Other _____

I would like to start my participation: ☐ Immediately ☐ On this date _____

Please designate my gift for:

☐ Hospital's greatest needs

☐ Staff wellness initiatives

☐ Education

☐ Equipment and technology

☐ Other (please specify): _____

_____

I would like to contribute by:

☐ Payroll deduction

☐ Automatic withdrawal from my bank account on the _____ day of each month.
Please attach a void cheque

☐ Automatic charge on my credit card on the _____ day of each month.

Credit Card Number: _____ _____ _____ _____ Expiry: _____

☐ My cheque is enclosed

I would like my contribution to be made anonymously: ☐ Yes ☐ No

Signature: _____

Please return this form to:

Orillia Soldiers' Memorial Hospital Foundation
146 Mississaga Street W., Orillia ON L3V 3B3
T: 705 . 325 . 6464 | F: 705 . 325 . 4693
events@osmh.on.ca