Ajax Pickering Hospital Foundation

Monthly Donor Authorization Form

Name _____

Address _____

City, Province, Postal Code _____

Phone Number _____

Email _____

This donation is made on behalf of: ○ an Individual ○a Business

Each month I would like to give

○ $20.00 ○ $15.00 ○ $10.00 ○ I prefer to give $_____

○ I have enclosed a blank cheque (marked VOID) and authorize the Ajax Pickering Hospital Foundation to deduct my gift from my bank account every month.

○ I prefer that the Ajax Pickering Hospital Foundation charges my gift above to my credit card each month

○ Visa ○ MasterCard ○ American Express

Card Number _____ Expiry Date _____/___

The debit will be processed to your account on the 15th day of each month or the next business day.

Signature: _____ Date: _____

I may revoke my authorization at any time, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

We respect your privacy. We do not rent, sell, or trade our mailing lists. The information you provide will be used to deliver services and to keep you informed on the activities of the Foundation. If at any time you wish to be removed from our mailing lists, simply contact us by phone 905.683.2320 x11501.

Charitable Registration # 14113 2662 RR0001