

## *YES* I want to support the Women's Health Clinic !

Here is my special gift!  \$25  \$50  \$100  Other \$ \_\_\_\_\_

I would like my donation directed toward  General Donation Fund  
 Women's Health Clinic Endowment Fund

### Payment Options

- Please find my cheque enclosed. Cheques are payable to: Women's Health Clinic
- I authorize Women's Health Clinic to draw a one time donation on the credit card specified below  
For your convenience... we are also able to offer the following :
  - I would prefer to make a donation through a **monthly contribution** of \$ \_\_\_\_\_ (minimum \$5 / month, I understand that I may change or cancel my donation at any time.)
    - I pledge \$ \_\_\_\_\_ per month for \_\_\_\_\_ months to be debited directly from my chequing account by:
      - Direct Donation Plan (Bank Acct Debit Authorization Form will follow our receipt of this pledge)
    - OR  12 post-dated cheques (enclosed)
  - I authorize Women's Health Clinic to draw donations on the credit card specified, once every month for a period of \_\_\_\_\_ months. Monthly gifts will be automatically processed at the end of each month with one receipt issued at the end of the calendar year.

### Credit Card Debiting:

- VISA  MasterCard

Card #: \_\_\_\_\_ Name of Cardholder: \_\_\_\_\_

Expiry Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Please complete for tax receipt purposes:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Company / Organization: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone (daytime): \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Fax (daytime): \_\_\_\_\_

(Tax receipts are issued for donations over \$10, or by request if under \$10)

### ***Thank You for your generosity and support !***

All donors will be listed in our Annual Report, unless otherwise requested.

Please indicate whether you wish to be included:

- Yes, include my name in the Annual Report  No, I would like my support to remain anonymous