NANAIMO & DISTRICT
HOSPITAL FOUNDATION
Funding Healthcare Needs • Central Vancouver Island

Monthly Giving Enrollment Form

Please print & complete this form and return to: Nanaimo & District Hospital Foundation, 102-1801 Bowen Road, Nanaimo, BC V9S 1H1 **or fax to**:250-755-7939 **or phone in your information to**: 250-755-7690.

***Donations will be processed at the beginning of each month, and you will receive an official tax receipt at year's end**

Personal Information

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

Title (Mr./ Mrs./ Miss)	Last Name	First Name

Street Address		
City	Province	Postal Code

Phone Number	E-mail Address

Action Requested

☐ Monthly donation from my bank account	Amount $_____
☐ Monthly Donation from my credit card	Amount $_____

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

Financial Institution Information (Electronic Funds Transfer only)

Attach your sample cheque marked **VOID**. If you do not have a void cheque, please have your financial institution complete the section below. The information must be for the account from which you would like the donations to be withdrawn

Name of Financial Institution			
Address	City	Province	Postal Code

Teller Stamp

Credit Card Information (Credit Card Payments Only)

Card Type ☐ Visa ☐ MasterCard ☐ American Express		
Account Number	Exp. Date	CSC #

Monthly Giving Authorization

I hereby authorize Nanaimo & District Hospital Foundation to withdraw the set amount of funds recorded in this document monthly from the above bank account/credit card and I may at any time discontinue these monthly donations.

Name (print)	Signature	Date

Privacy Statement: Nanaimo & District Hospital Foundation protects your personal information and adheres to all legislative requirements with respect to protecting your privacy.

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 the PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

I may revoke my authorization at any time, subject to providing notice of (Payee to insert period – not to exceed 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.