Monthly Donation Preauthorization Form

Please complete all sections fax to QCH Foundation 613-721-4755
or scan and email to qchfound@qch.on.ca

CONTACT INFORMATION

This donation is being made on behalf of an (check one): ☐ Individual ☐ Business

Name				
Address				
	Number & Street Name	City	Province	Postal Code

Contact #	(613)	(613)	(613)	(613)
	Home Number	Work Number	Cell Number	Other

Email	

CREDIT CARD INFORMATION

Name(s) on Card	
Card Number	
Card Expiry Date	

ACCOUNT INFORMATION (or attach a void cheque)

Names of Account Holder(s)	

| | | | | |	| | | |	| | | | | | | | | | | | | | | | |
Transit #	Institution #	Account #

TRANSACTION INFORMATION

Monthly Donation Yes ☐ No ☐ Donation Amount $ _____

☐ Please cancel my monthly donation

I (we) hereby authorize Queensway Carleton Hospital Foundation to withdraw from my (our)credit card or Bank account the above (Transaction Information) monthly donation. I understand that I can alter the amount of my monthly gift or end this service any time with a simple phone call to the Foundation office at 613-721-4731. For further information on your right to cancel a PAD Agreement and / or recourse rights, please contact your financial institution or visit www.cdnpay.ca

_____ _____

Signature of Account Holder Date

Charitable Organization # 137253571RR0001