Baker Centre
Health Care Foundation

Donation Form

Name: _____

Address: _____

Phone: _____

Email: _____

☐ I wish my gift to remain anonymous

For a **one-time donation**

☐ I would like to make a one-time donation to the Baker Centre Health Care Foundation

Enclosed is my donation of: ☐ $50 ☐ $75 ☐ $100 ☐ My choice $ _____

☐ Bill my credit card ☐ VISA ☐ Mastercard ☐ American Express

Card Number: _____ Exp. Date: _____ (MM/YY)

Signature: _____

☐ My cheque is enclosed *(...cheques are payable to the "Baker Centre Health Care Foundation")*

For a **monthly donation**

☐ I would like to make a monthly donation of $ _____ to the Baker Centre Health Care Foundation

☐ I hereby authorize the Baker Centre Health Care Foundation to automatically bill my credit card.
I understand that I may always cancel this authorization at any time with written notice.

☐ Bill my credit card ☐ VISA ☐ Mastercard ☐ American Express

Card Number: _____ Exp. Date: _____ (MM/YY)

Signature: _____

Monthly withdrawal date: ☐ 1st ☐ 15th ☐ 28th

☐ My post-dated cheques are enclosed *(...cheques are payable to the "Baker Centre Health Care Foundation")*

Please return this form to: **Baker Centre Health Care Foundation**
1 Northwestern Avenue
Toronto, Ontario M6M 2J7

Tax receipts will be issued for all gifts of $20 or more.

Charitable Registration Number: 871962841RR0001