GRACE HOSPITAL
FOUNDATION

Donation Form

Your gift to Grace Hospital Foundation directly supports patient care enhancements that would not otherwise be funded by the government, and helps assure that every patient who comes to the Grace has access to the best care possible.

Donor Name ____

Home Address _________________________________ **Unit/Apt. #** ____________________

City/Prov. _____________________________________ **Postal Code** ___________________

Email __________________________________ **Phone** __________________

Donation Type ☐ General Patient Care Fund ☐ Memorial Tribute (Please fill out information below) ☐ Monthly Giving

In Memory of ____

Next of Kin Name ____

Next of Kin Address ____

Donation Amount $ ____________ **Monthly Donation Amount** $ _______

Payment Type: ☐ Cash ☐ Cheque *(Payable to "Grace Hospital Foundation")* Credit Card ☐ Visa ☐ Master Card ☐ AMEX

Credit Card Number ____

Card Expiry Date _________/_________ **3-Digit CVV Code** ______________________________

Additional notes or messages: ____

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Please contact the Grace Hospital Foundation at 204-837-0375 if you have any questions.

Thank you for your support!