



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:				
City/Prov.:		Postal Code:		
Email:		Phone:		
Donation Type:	□ General Patient Care□ Hospice	□ Memorial Tribute (Please fill out information below)		□ Monthly Giving
In Memory of:				
Next of Kin Name	e:			
	ess:			
Donation Amount: \$		Monthly Donation Amount: \$		
Payment Type:	□ Cash	□ Cheque (Payable to "Grace Hospital Foundation")	Credit Card	□ Visa
				□ Master Card
				□ AMEX
Credit Card Nun	nber:			
Expiry Date:		CVV Code:		
Additional notes	or messages:			

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

Thank you for your support!