

Donation Form



Please Print

This gift is from: **An Individual** *OR* **An Organization**

Individual Gift:

Title: _____ First Name: _____

Last Name: _____

Address: _____ Suite: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____

Email: _____

I agree to receive email communications from The Scarborough Hospital Foundation.

Organization Gift:

Organization Name: _____

Address: _____ Suite: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____

Contact at Organization:

Title: _____ First Name: _____

Last Name: _____

Email: _____

I agree to receive email communications from The Scarborough Hospital Foundation.

I would like to make a gift of: **\$50** **\$100** **\$150** **\$250** **\$500** **I prefer to give \$** _____

I have enclosed a cheque made out to The Scarborough Hospital Foundation

Please charge my: **Visa** **MasterCard** **American Express**

Card Number: _____ Expiry Date: _____

Cardholder's Name: _____

Please mail your donation form to:
The Scarborough Hospital Foundation
3030 Lawrence Ave. E., Suite 108
Scarborough, ON M1P 2T7

OR

Email your form to:
foundation@tsh.to

Thank You For Supporting Your Scarborough Hospital