

Donor contact

DONATION FORM

Thank you for supporting the Lachine Hospital Foundation

Donor Contact		
☐ Mr. ☐ Mrs.	☐ Ms.	
Last name:		First name:
Company name:		
Address:		City:
Province:		Postal code:
Phone:		E-mail:
Language of correspondence: □ French □ English		
Payment		
Amount: \$ \(\sigma \) \\$ 50 \$ \(\sigma \) \\$ 75 \$ 100 Other: \(\sigma \)		
□ Cash	☐ Credit card	
☐ Cheque Made to the order of the Lachine Hospital Foundation	□ Visa □ Master	rCard
	Card number:	
	Expiry date:	CVV code:
	Name of the card hold	er:
	Signature:	