Calvary | Riverina Hospital

Hospitality
Healing
Stewardship
Respect

Donation Form

Your Details

☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other ________________

First name ____________________________ Surname ________________________________

Company ____

Postal Address ____

State ______________________ Postcode _____________

Telephone ______________________ Email ________________________________

Your Donation

Please accept my donation of

☐ $25 ☐ $50 ☐ $100 ☐ $200 ☐ Other ________________

☐ One time only ☐ Monthly ☐ Annually

If you have selected monthly or annual donations, your donation will be deducted from the credit card nominated below on a monthly or annual basis as specified. You may provide notice to us in writing at any time to cancel this authority.

Please direct my donation to

☐ Palliative Care (PC) ☐ Bequests (B) ☐ General (G) ☐ Other (O) – please give details below

____

Payment Details

I am paying by

☐ Visa ☐ MasterCard ☐ Cheque* ☐ Money Order* ☐ Direct Debit

** Please make Cheques or Money Orders payable to* ***Calvary Health Care Riverina***

Card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry date: ☐☐ / ☐☐ CVC: ☐☐☐

Cardholder's name ____________________________ Signature ________________________________

Direct Deposits
Name: CHCR Gift Fund
BSB: 062-614
ACC 10263386
Reference: Purpose Your Name

Eg (PC John Smith) (B John Smith) (G John Smith) (O John Smith)

OFFICE USE ONLY

Account and Cost Centre:

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Please forward completed form to
Chief Executive Officer
Calvary Riverina Hospital
23-36 Hardy Avenue
Wagga Wagga NSW 2650

Enquiries

02 6925 3055

Thank you! Donations over $2 are tax deductible and your receipt will be mailed to you.