

# Donation Form

## Your Details

Mr     Mrs     Ms     Dr     Other \_\_\_\_\_  
 First name \_\_\_\_\_ Surname \_\_\_\_\_  
 Company \_\_\_\_\_  
 Postal Address \_\_\_\_\_  
 State \_\_\_\_\_ Postcode \_\_\_\_\_  
 Telephone \_\_\_\_\_ Email \_\_\_\_\_

### Stay in touch with Calvary Public Hospital Bruce

Email     Mail     I do not wish to receive updates

## 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

General Donation     Research     Education     Training     Equipment  
 Other – please give details below if you want to donate to a particular service or clinical discipline

## Payment Details

### I am paying by

Visa     MasterCard     Cheque\*     Money Order\*

\* Please make Cheques or Money Orders payable to **Calvary Public Hospital Bruce**

Card number:

Expiry date:   /

Cardholder's name \_\_\_\_\_ Signature \_\_\_\_\_

### Please forward completed form to

Donations & Bequests  
 Calvary Public Hospital Bruce  
 PO Box 254  
 JAMISON CENTRE ACT 2614

### Enquiries

02 6201 6111

### OFFICE USE ONLY

Account and Cost Centre:  
\_\_\_\_\_

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