



RECURRING GIFT FORM **by Credit Card only**

To donate to L & A Hospital Foundation by making a recurring gift or a pledge, please complete this form.

BILLING INFORMATION

First Name: _____ Last Name: _____

Address: _____ Apt# _____

City: _____ PROV: _____ Postal Code: _____

Phone #: _____ E-mail: _____

GIFT INFORMATION

How frequently would you like to donate? ___monthly ___quarterly ___annually

How much would you like to donate each time? \$ _____

When do you want the donation to start? _____ end date? _____
day/month/year day/month/year

Pledge total \$ _____

I understand this amount will be automatically charged to my credit card for the time period selected below.

DESIGNATION

Campaign: _____

Fund: _____

PAYMENT METHOD

Credit Card Information:

Name as it appears on card: _____

Card Type: ___ Visa ___ MasterCard

Credit Card Number: _____ Security # _____

Credit Card Expiration Date: _____

Pay by Check:

To pay by cheque each month, please check here: _____

Please attach post dated cheques.

*Thank you for your commitment to the Lennox and Addington County General Hospital Foundation
Please read and sign the following: I hereby authorize Lennox & Addington County General
Hospital Foundation to initiate credit card entries. I have read and understood the above.*

Signature: _____ Date: _____