Royal University Hospital Foundation

Women Leading Philanthropy

DONOR REGISTRATION

March, 2019

YOUR INFORMATION

Title ________ First Name ____________________________ Last Name ___________________________________

Address ______________________________________ City _____________________ Prov _______ PC ________

Telephone _______________________ DOB ______________ Email _______________________________________

Name will appear as above for WLP recognition purposes unless advised otherwise. ❑ I wish my gift to be anonymous.

YOUR GIFT

Donation Amount: ❑ $600/year (under 40 years) ❑ $1,200/year (40+ years) ❑ Other ____________________

❑ One time ❑ Monthly (on the 20th of each month, continuously unless the donor requests to discontinue)

Payment Type: ❑ Visa ❑ Mastercard ❑ Cheque Enclosed (marked "VOID" for monthly donations)

Credit Card # ____ Expiry ____________ CSV _______

Name on Card ____

❑ My company will match my gift! Company Name: ____

Address ______________________________________ City _____________________ Prov _______ PC ________

THANK YOU!

A charitable tax receipt will be issued for donations of $20 or more and once per year for monthly donations.

❑ I affirm that entering my information above and submitting this form constitutes an electronic signature of this form. By completing this form, I also give my consent to be photographed, video/audio taped or otherwise recorded during my attendance at WLP events and for the information obtained to be used in any form (print, electronic, web, social media), for the purposes of promotion of the WLP program.

Date ______________________

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Funding year for WLP is July 1 to June 30