



MONTHLY DONATION FORM

START DATE: _____, 20____

IN PERSON
 E-MAIL

MAIL
 PHONE

Mr. ___ Mrs. ___ Miss ___ Ms. ___ Dr. ___

(LAST NAME) (Print Legibly)

(FIRST NAME)

(ADDRESS)

(SPOUSE FIRST NAME)

(CITY)

(RESIDENCE PHONE #)

(PROVINCE) (POSTAL CODE)

(BUSINESS PHONE #)

(EMAIL ADDRESS)

For office use only

(Const. ID Number)

(Fund)

(Campaign)

(Appeal)

I will join the monthly payment plan by giving
 \$5 \$10 \$20 or \$_____ per month
The debit will be processed to your account the first business day of the month.

By pre-authorized chequing henceforth SMDF and its agent bank may automatically debit my account on the first day of each month for the above amount. I authorize my bank to pay this amount from my chequing account. I've enclosed a void cheque

I'll donate each month by credit card: Visa MasterCard American Express
Card Number: _____ Expiry Date: ____/____
Signature: _____ Date: _____

DONATION RECEIVED FOR:

GENERAL DONATION

SPECIFIED DONATION: PURPOSE: _____

OTHER: _____

I understand that I may cancel my bank or credit card authorization at any time with written notice to SMDF. For more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca. I also understand that I will receive a tax receipt at year-end for the total of my donation. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Thank You.

AUTHORIZATION: _____