

Holland Bloorview

Kids Rehabilitation Hospital Foundation

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T (416) 424-3809
F (416) 425-4531
www.hollandbloorviewfoundation.ca

Donation Form

Donor Information

Name: Mr./Mrs./Ms/Mr. & Mrs./Other _____

Address: _____

Phone: Business: () _____ x _____ Home: () _____

Email: _____

Gift Information

I'd like to make a one-time donation of \$ _____

I'd like to pledge a total of \$ _____ Payable (amounts/dates): _____

Please provide any notes below (i.e. gift designation):

Payment Information

Cash

Cheque (made payable to **Holland Bloorview Kids Rehabilitation Hospital Foundation**)

Credit Card

Credit Card Type: Visa Mastercard American Express

Credit Card Number: _____

Credit Card Expiry Date: _____ / _____

Security Code: _____ (3 digits on back of card for Visa and MC, 4 digits on front of card for Amex)

I'd like to receive a call from a Foundation staff member about:

making a Gift of Securities

making a Planned Gift

becoming a monthly donor

other: _____

Date: _____

Signature: _____