



# Donation Form

Lake of the Woods District Hospital Foundation  
21 Sylvan Street W.  
Kenora, Ontario  
P9N 3W7 Tel: (807) 468-9861 Ext. 2469

Name of Donor: \_\_\_\_\_

Please Check One:

Mr. & Mrs.     Mr.     Mrs.     Ms.     Miss

Address of Donor: \_\_\_\_\_

City: \_\_\_\_\_ Province/State: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Amount Given: \$

Donation Made In Form Of:

Cash     Cheque # \_\_\_\_\_     Visa     MasterCard     Amex

Credit Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiry Date: \_\_ \_\_ / \_\_ \_\_ Authorization: \_\_\_\_\_

## Acknowledgement

Who is the donation in memory of?

\_\_\_\_\_

Please send an acknowledgement card to:

\_\_\_\_\_

\_\_\_\_\_

Additional Information / Designate Funds to: