DRESDEN COMMUNITY HEALTHCARE FOUNDATION

You are an important part of this building project!

About You: (Please check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.		
First	Middle Initial	Last
Mailing Address	City	Postal Code
Telephone	E-Mail Address	
Company Name		
Name for Income Tax Receipt Purposes		

Your Gift to the Dresden Community Healthcare Foundation (DCHF):

My Total Gift

$ _____

_____
Signature to authorize pledge
(Required)

_____
Date (dd/mm/yyyy)

Cash/Cheque

☐ Cash

☐ Cheque (cheque #____)
Please make cheque payable to the Dresden Community Healthcare Foundation

☐ Post-dated cheque enclosed

Pledge Payment Information

Frequency: ☐ Yearly ☐ Monthly

Start Date: _____
(dd/mm/yyyy)

Duration: ☐ 1 Yr ☐ 2 Yrs ☐ 3 Yrs

Amount per Pledge Payment: $ _____

☐ I/We give the Dresden Community Healthcare Foundation permission to list my/our names for donor recognition purposes. My/Our name(s) must be printed as follows:

_____

_____
Signature Date

☐ I/We wish to be anonymous

Your contribution is fully tax-deductible.

DCHF is commited to privacy.

The DCHF is commited to protecting personal information by following responsible handling practices to complete payment transactions and satisfy regulatory obligations.