

Group Donation Form

2015 ST. PAUL'S HOSPITAL FAMILY CAMPAIGN

Please fill in every field so we can ensure your donation is properly attributed and recognized.

Admin contact

TITLE	FIRST NAME	LAST NAME
DEPARTMENT / DIVISION / PROGRAM		
ADDRESS		
EMAIL	PHONE	
<input type="checkbox"/> Contact me by email		

Group leader (If different to Admin Contact)

TITLE	FIRST NAME	LAST NAME
DEPARTMENT / DIVISION / PROGRAM		
ADDRESS		
EMAIL	PHONE	
<input type="checkbox"/> Contact me by email		

Group gift (choose one)

- We would like to make a one-time gift of \$ _____
- Multi-year pledge of \$ _____ for the next _____ years

To make sure that we are able to put your name or company name on the display in time for the public Lights of Hope Lighting Celebration, **please send your gift or pledge and payment arrangements by October 4, 2015.**

Payment method (choose one)

- Cheque Enclosed (Payable to St. Paul's Hospital Foundation) Acknowledgement receipt will be sent to the Admin Contact.
- Visa Mastercard Amex

CARD NUMBER		EXPIRY DATE (MM/YY)	
NAME ON CARD	SIGNATURE		

Use of gift (choose one)

- 100% Greatest Needs
- _____ % Greatest Needs (25% min to receive Lights of Hope recognition) and _____ % to _____

Recognition (How your name is displayed)

Please see the Lights of Hope Recognition Chart for details

My Group name should appear as: _____

Please list all donors on the reverse, so we can issue tax receipts and recognize their giving.

turn over →

Mail, drop off, or fax your donation to:

St. Paul's Hospital Foundation
Suite 178 - 1081 Burrard Street
Vancouver, BC V6Z 1Y6

Tel: 604.682.8206
Fax: 604.806.8326
scruikehan@providencehealth.bc.ca

Donate online at www.lightsofhope.com

Please allow up to four weeks for a tax receipt.
Charitable registration number: 11925 7939 RR0001

Group Donors

TITLE FIRST NAME LAST NAME

DEPARTMENT / DIVISION / PROGRAM

ADDRESS

EMAIL PHONE

GIFT AMOUNT \$ _____ I give permission to list my name. My name should appear as: _____
 Contact me by email

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