

**The Leamington District Memorial Hospital
Foundation**

~YOU CAN MAKE THE DIFFERENCE~

Complete this form and mail your donation in support of the Leamington District Memorial Hospital.

DONOR INFORMATION

Name: _____

Address: _____

Town/City: _____

Postal Code: _____ Phone: _____

Date _____

Memorial Tribute: In Memory of: _____

\$20 _____ \$50 _____ \$100 _____ \$200 _____ \$500 _____ \$1,000 _____

Other Amount: _____

Cheques payable to:

Leamington District Memorial Hospital Foundation

194 Talbot Street West

Leamington, ON N8H 1N9

Ph: 519-326-2373 (4143)

Fx: 519-322-5584

CREDIT CARD INFORMATION: Visa Mastercard

Card Number: _____

Expiry Date: _____

Signature: _____

An income tax receipt will be issued promptly for donation of \$10.00 or more.