Giving is easier when you give monthly. Please see reverse.

Yes! I want to help babies like Jake survive.

Payment Method

☐ Cheque payable to BC Women's Hospital & Health Centre Foundation (BCWHCF)

OR

Please charge my: ☐ VISA ☐ MasterCard

Card Number _____ Expiry Date _____

Name of Cardholder _____

Signature _____

The Leader In Women's Health
Women's
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Monthly Giving Program

I authorize BC Women's Hospital & Health Centre Foundation to automatically withdraw: ☐ $20 ☐ $35 ☐ $50 ☐ Other $_____

from my bank account on the **1st** or **15th** (circle one) day of each month until further notice. I have enclosed a cheque marked VOID.

Signature _____

OR

Please debit my credit card ☐ VISA ☐ MasterCard in the amount of: ☐ $20 ☐ $35 ☐ $50 ☐ Other $_____

on the **1st** or **15th** (circle one) day of each month until further notice.

Card Number |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Expiry Date |_|_|_|_|

Name of Cardholder _____ Signature _____

You will receive a tax receipt for the total amount of monthly gifts on an annual basis. You may cancel your pledge at any time.

B.C. Women's Hospital & Health Centre Foundation

4500 Oak Street, Room 1U64, Vancouver, B.C. V6H 3N1, 604-875-2270

Charitable Registration Number 890267537RR0001

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