DAYSLAND
HOSPITAL FOUNDATION

Join us to strengthen our community
and enhance health care together

I WANT TO ENHANCE HEALTH CARE

I would like to make a donation of ☐ **$50** ☐ **$75** ☐ **$100** ☐ **$250** ☐ **Other**__________

☐ I have enclosed a cheque payable to **Daysland Hospital Foundation**

To donate online, please visit **dayslandhospitalfoundation.com**

☐ MRS ☐ MS ☐ MR ☐ OTHER FIRST NAME LAST NAME

ADDRESS CITY PROVINCE POSTAL CODE

PHONE EMAIL

Please designate my gift towards:

- ☐ **Current Fundraising Priorities**
- ☐ **Palliative Care Unit**
- ☐ **Medical Clinic**
- ☐ **Where it is needed the most**

I would like to pay by credit card: ☐ **VISA** ☐ **MASTERCARD**

CARD NUMBER _ _ _ _/_ _ _ _/_ _ _ _/_ _ _ _ EXPIRY DATE _ _/_ _

CARDHOLDER'S NAME ☐ BUSINESS CARD

SIGNATURE DATE

Mail your donations to: Daysland Hospital Foundation, Box 27, Daysland, AB T0B 1A0

Registered Charitable BN: 118883289 RR0001