

YES, I WANT TO SUPPORT MY
COMMUNITY HOSPITAL

PLEASE PRINT

Name _____

Address _____

Postal Code _____ Telephone _____

Please accept my donation of:

\$25 \$50 \$100 \$250 Other

Cheques are made payable to:

Cowichan District Hospital Foundation

Or, Please charge my VISA MASTERCARD

Credit Card # _____

Expiry Date _____

Signature _____

Occasion, Event or donate to Most Needed: _____

In Memory of _____

Next of Kin _____

Next of Kin Address _____

_____ Prov _____ Postal _____

Comment: _____



#4 – 466 Trans Canada Hwy
Duncan, BC V9L 3R6
Ph: 250-701-0399 Fax: 250-701-0339