



GRACE HOSPITAL
FOUNDATION



DONATION FORM

Your donation to the Grace Hospital Foundation directly contributes to staff and patient care enhancements that go beyond government funding, ensuring every person receives the highest quality care possible.

Donor Information

Name: _____

Home Address: _____

City/Province: _____ Postal Code: _____

Email: _____ Phone: _____

Donation Type

- Area of Greatest Need
- Grace Hospice
- Memorial Tribute (Complete the section below)

In Memory of: _____

Next of Kin Name: _____

Next of Kin Address: _____

Donation Information

Donation Amount: _____

Payment Type

- Cash
- Cheque (Payable to Grace Hospital Foundation)
- Credit Card Visa MasterCard AMEX

Credit Card Number: _____

Expiry Date (MM/YY): _____ CVV: _____