Donation Form

Monash Children's Hospital
www.monashchildrens.org.au

My Contact Details (please print clearly)

Title: _____ First name: _____ Last name: _____

Company: _____ Position: _____

Mailing address: _____

Suburb: _____ State: _____ Postcode: _____

Email: _____

Phone (day): _____ Mobile: _____

My Gift

☐ I would like to make a single gift of: $ _____

☐ I would like to make a regular gift of $ _____

☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Yearly

I would like my gift to be directed to:

☐ Where it is most needed ☐ Other (please nominate area) _____

☐ Please send me information about leaving Monash Children's Hospital a gift in my will

☐ Please keep me informed about the work of the Monash Children's Hospital

Recognition (donors will be recognised in campaign materials unless they wish to remain anonymous)

☐ I (we) wish to remain anonymous ☐ This gift is in honour/memory of: _____

☐ I (we) agree to be recognised. Please use the following names in all acknowledgments: _____

My Payment Details

☐ Please invoice me

I would like to pay by: ☐ Cash ☐ Visa ☐ Mastercard ☐ Direct Debit* ☐ Cheque/Money Order**

*A Direct Debit Authorisation Form will be sent to you **Please make payable to Monash Health Foundation

Card number: |___|___|___|___| |___|___|___|___| |___|___|___|___| |___|___|___|___|

Expiry date: |___|___| |___|___|

Cardholder's name: _____ Cardholder's signature: _____

Donations of $2 and over are tax deductible. Please allow seven business days to process your donation. A receipt will be sent by mail/email.

Thank you!

Thank you for supporting exceptional healthcare at Monash Health.
Please send completed form to: **Monash Health Foundation, Locked Bag 29 CLAYTON SOUTH VIC 3169**