Locked Bag 5
ADELAIDE SA 5001
Tel: (08) 8464 7900
Fax: (08) 8464 7999

I / We are pleased to make a donation to the Women's & Children's Hospital Foundation

Please print clearly your name and/or business name as you would like it to appear for the appropriate recognition.

DONOR NAME: (Mr/Mrs/Dr/Ms/Miss) _____

CONSTITUENT ID: (if known)_____

COMPANY: (if relevant) _____

ADDRESS: _____

_____ Postcode _____

TELEPHONE NO. [Daytime] _____ [Mob] _____

I / WE WISH TO DONATE $_____

☐ Cheque/ Money Order enclosed (made payable to the **WCH Foundation**)

☐ Please charge my gift to

☐ VISA ☐ Mastercard ☐ Diners ☐ AMEX

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date: ___ / ___

Cardholder Name: _____ Signature: _____

Is this an In-Memory donation YES / NO

Name of Deceased: _____

Next of Kin details: _____

_____

Extra Comments: _____

_____

- I understand that I may alter my pledge at any time should circumstances warrant such action
- All donors will be recognised unless otherwise requested, but amounts of gifts will not be disclosed.

Signature: _____ **Date:** _____