Children's Leaders

Children's Leaders Donor Pledge:

As a **Children's Leaders** donor, I agree to:

- Participation in the program for two years, with continued extension as mutually determined
- Contribute a minimum of $2,000 (over 2 years) to a collective gift which will be designated to a priority area as selected by the collective membership
- Attend four (4) **Children's Leaders** events throughout the year and offer to host one during my term
- Reach out to my network to spread awareness of Children's and our health care partners
- Strive to increase the profile and recognition of Children's Health Foundation as the #1 Children's philanthropic organization in Southwestern Ontario
- Target key "movers and shakers" in London's young professional population to join Children's Leaders

____

Signature | Date

____

Received by Children's Health Foundation | Date

Please complete the front and back of this form and return to Children's Health Foundation by e-mail at childrensleaders@childhealth.ca or send to 345 Westminster Avenue, London, ON N6C 4V3.

Donor Information Form

Please tell us about yourself

(Title) Mr. Mrs. Ms. Miss Dr. First Name Initial Last Name

Street Number Street Name Apt/Unit # City Postal Code

Home Phone Home Email

Business Phone Business Email

Preferred point of contact: ◯ Home ◯ Business

◯ For recognition purposes, I'd prefer to have my name listed as: ____________________

◯ I'd prefer not to have my name published as a donor

Gift Information

◯ Yes, I want to support Children's by making a gift of $2,000.00. Please designate my gift to the Children's Leaders Fund.

Payment Information

Option 1:

I'd like to make a one time payment of $2,000.00

My gift will be paid by: ◯ Personal cheque/postdated cheques (Payable to **Children's Health Foundation**)

◯ Automatic debit on 15th of each month

◯ I'd prefer to make my gift by credit card ◯ VISA ◯ MasterCard ◯ American Express

Credit Card Number Expiry Date (MM/YY)

Option 2:

I'd like to pay my gift over ________ months, beginning __________ and ending ____________

(Month/Year) (Month/Year)

My gift will be paid by: ◯ Personal cheque/postdated cheques (Payable to **Children's Health Foundation**)

◯ Automatic debit on 15th of each month

◯ I'd prefer to make my gift by credit card ◯ VISA ◯ MasterCard ◯ American Express

Credit Card Number Expiry Date (MM/YY)

Please sign and date

I understand that this amount will be deducted from my bank account or charged to my credit card automatically on the15th of each month or next business day. I may revoke my authorization at any time, subject to providing notice to Children's Health Foundation allowing 30 days for processing. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca. I agree to waive my right to receive pre-notification of any debits under this agreement. I acknowledge that I can request to make changes to the amount noted above simply by contacting Children's Health Foundation

Signature Month/Day/Year