KOLLING Foundation | Royal North Shore Hospital

Support health and medical research

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DONATION FORM – Monthly Tax Deductable Gift Form

Yes, I would like to 'Sponsor a Cure'.

PERSONAL DETAILS

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Prof ☐ Other .....

First Name: ..... Last Name: .....

Address: .....

Town/Suburb: ..... State: ..... Postcode: .....

Phone (BH): ..... Phone (AH): .....

Fax: ..... Mobile: .....

Email: .....

How did you hear about Kolling? .....

PLEASE ACCEPT MY DONATION

Monthly gift amount: $ .....

For research into: ☐ **Area of greatest need**, OR

☐ **Other (please specify): .....**

☐ OPTION 1 - CREDIT CARD

I authorise Kolling Foundation to charge the above mentioned amount to my credit card on ..... day of each month.

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Amercian Express

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ CCV No.: .....

Name on Card: ..... Expiry Date: ..... / ..... / .....

Signature: ..... Date: .....

☐ OPTION 2 – DIRECT DEBIT

I/We authorise Kolling Foundation to debit the above mentioned amount from my/our account on ..... day of each month at the financial institution identified below. Acting on my/our instructions the Kolling Foundation may, by prior arrangement and advice to me/us, vary the amount for future debits.

Financial Institution: .....

BSB: ☐☐☐ ☐☐☐ Account number: ☐☐☐☐☐☐☐☐

Account Name: .....

Signature: ..... Date: .....

Signature: ..... Date: .....

PRIVACY STATEMENT

The information provided by you will only be used for the purpose of giving you information about Kolling.

☐ Tick if you do not want to receive information about the work of Kolling.