Monthly Giving Program

Yes, I would like to support the **Partners for Hope Monthly Giving Program**

This donation is made on behalf of: Individual Company

Name of Donor: Dr. Mr. Mrs. Ms. Mr.& Mrs.

Tax Receipt Issued to:

Mailing Address:

Telephone Number:	**Fax Number:**	**E-mail:**

Choose one of the 3 options to make your donation:

1. **Cheque** Send post-dated cheques. Please make cheques payable to ALS Society of BC.

2. **Credit Card** : Visa MasterCard Amex	Name on the Credit Card:

Credit Card Number:	Expiration Date:	Security Code # (3 digit for Visa & MasterCard at the back of the card & 4 digit in-front of the card of Amex)

3. **Debit my Bank Account** Please attach void cheque

Preferred charge date: ____1st of the Month _______15th of the Month ____________________Other preference

Note: The Bank/Credit Card account will be charged on the next business day if the schedule date falls on a weekend or holiday

- I, as the bank/credit card holder of the account, authorize the ALS Society of BC to debit my donation from my bank account or credit card every month in the amount of (please check or indicate your preference):

  ___$10 _____$20 _____$25 _____$50 ______$100 ______Other Amount

- I understand that I can cancel my direct donation at any time, simply through phone call or a written notice to ALS Society of BC.
- A tax receipt for my monthly donation will be issued to me every December of each year.

Signature of Account Holder_______________________________ Date:_________________

Return form by mail: ALS Society of BC
1233 – 13351 Commerce Parkway Richmond, BC V6V 2X7

By Fax: 604.278.4257	**E-mail**: info@alsbc.ca	**Telephone Inquiry**: 1.800.708.3228 ext. 225