



CANADIAN MENTAL
HEALTH ASSOCIATION
ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

CANADIAN MENTAL HEALTH ASSOCIATION – NATIONAL

MONTHLY GIVING PROGRAM

Yes, I agree to donate monthly to the Canadian Mental Health Association. I would like to make a donation of \$ _____ on the 15th of each month beginning _____ (month) _____ (year).

I would like this donation to be allocated to:

- [] \$ _____ CMHA National
- [] \$ _____ (name) CMHA Division
- [] \$ _____ (name) CMHA Region

Full Name _____

Address _____

City/town _____ Postal code _____

Phone () _____ (day) () _____ (evening)

E-mail (optional) _____

Name(s) to be Recognized _____

I would like to donate by:

- [] Electronic Transfer (automatically from my chequing account). Please enclose a cheque marked VOID.

Or:

- [] Visa [] Master Card [] American Express

Card # _____ Name on card _____ Exp. _____

I hereby authorize the Canadian Mental Health Association, National, to make automatic monthly withdrawals from my bank account or credit account, as indicated above. I understand that I may cancel this authorization at any time by notifying the Association in writing.

Signature _____ Date _____

Tax receipts are issued at the end of the calendar year.

~ Your support is greatly appreciated ~

Please fax completed forms (with photocopy of VOID cheque, if required) to 416-484-4617 or mail to Canadian Mental Health Association, National Office, 180 Dundas Street W., Suite 2301, Toronto, ON M5G 1Z8