

Michael House Pregnancy Care Centre



YES! I would like to become a Michael House Angel and help the mothers and babies in need of shelter and support in my community.

_____ \$25 _____ \$50 _____ \$75 Other Amount (specify) \$_____ Monthly

Method of Payment

_____ My Check/Post-dated Checks are enclosed

_____ Credit Card (please check either: _____ Visa _____ MC)

Card # _____ Expiry Date _____

Name on Card _____ Signature _____

_____ Please Debit my Bank Account: (**attach VOID cheque**)

The debit will be processed to your account on the 1st _____ 15th _____ day of each month or the next business day.

Signature: _____ **Date:** _____

Donor Name (Please print) _____ Address _____

City/Prov. _____ PC _____ Phone _____ E-mail _____

This donation is made on behalf of: _____ an Individual _____ a Business

I may revoke my authorization at any time, subject to providing notice of 30 days. 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.

SEND ATTACHED FORM TO: MICHAEL HOUSE PREGNANCY CARE CENTRE
P.O. Box 24045 GUELPH ON N1E 6V8 519-766-7675 OFFICE@MICHAELHOUSE.CA