shalem
Mental Health Network

Date: _____

I want to support the Shalem Mental Health Network through monthly donations.

Please debit my bank account monthly: (attach VOID cheque)

☐ $25 ☐ $50 ☐ $75 ☐ $100 Other Amount _____ (please specify)

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

Signature: _____

Donor Name: _____

Address/Contact Information: _____

_____

Telephone and email address: _____

This donation is made on behalf of: ☐ individual(s) ☐ 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 cancelling this 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

Please mail or fax this form with a cheque marked VOID to:

Shalem Mental Health Network
875 Main Street East
Hamilton, ON L8M 1M2
905.528.0353 866.347.0041 Fax: 905.528.3562
office@shalemnetwork.org