Pre-Authorized Debit (PAD) Agreement

Central Northeast Health Foundation **Date:______________**

I want to support the Central Northeast Health Foundation through automatic monthly donations directly from my bank account.

Please debit my bank account: *(Please attach a **Void** cheque)*

_____$25 _____$50 _____$75 Other Amount______(Specify)

The debit will be processed to your account on the 18th day of each month or the next business day.

Signature: ____________________________________

Donor Name: ____________________________________

Address/Contact Information: ____________________________________

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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.

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Gander, NL A1V 1W6
Tel: (709) 256-5742 Fax: (709) 256-4350
E-mail: foundation@centralhealth.nl.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.