childhood asthma FOUNDATION

I would like to support The Childhood Asthma Foundation

NAME: ❑MR. ❑MRS. ❑MS. ❑MISS_____

BUSINESS NAME (If applicable):_____

ADDRESS:_____

CITY/PROV:_____POSTAL CODE:_____

TELEPHONE: ( )_____

By making pre-authorized monthly donations, you help reduce administrative costs. This means more of your donation is used for research and public education.

❑ VISA ❑ MASTERCARD ❑ CHEQUE

Card No.__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Card Expiry Date:__|__|-__|__|

Name on Card:_____Signature:_____

Donation Amount: ❑**$30** ❑**$50** ❑**$100** ❑**$200** ❑ **Other**_____

OR: ❑ I prefer to make a monthly donation of $ _____

I would like to make my donation by ❑ credit card
❑ chequeing account(voided cheque enclosed)

Use your browser's PRINT button to print this form and mail to:

Childhood Asthma Foundation
Box 22033 Riall Heights
Niagara Falls, ON
L2J 9Z9

or
FAX: 1-905-357-9469