

**Personal Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Option 1 – Monthly Donation**

<input type="checkbox"/>	Yes I want to join the <i>Recovery Net</i> by making a monthly donation  I authorize CMHA/Peel branch to withdraw the following amount from my bank account or my credit card on the 15 <sup>th</sup> of every month. I may change the amount or cancel my monthly contribution at any time by notifying CMHA/Peel Branch.
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<input type="checkbox"/> \$5	<input type="checkbox"/> \$10	<input type="checkbox"/> \$15	<input type="checkbox"/> \$25	Other \$ _____
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<input type="checkbox"/> I have enclosed a cheque, marked void, for CMHA/Peel to arrange an automatic withdrawal from my bank account	
<input type="checkbox"/> I prefer to make my monthly donation by credit card	<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard
Card #: _____	Expiry: _____
Signature: _____	

**Option 2 – One-time donation**

<input type="checkbox"/>	I prefer to make a one-time donation of
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<input type="checkbox"/> \$35	<input type="checkbox"/> \$60	<input type="checkbox"/> \$100	<input type="checkbox"/> \$250	Other \$ _____
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<input type="checkbox"/> I want to make my gift by cheque or money order (payable to Canadian Mental Health Association/Peel Branch)	
<input type="checkbox"/> I prefer to use my credit card	<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard
Card #: _____	Expiry: _____
Signature: _____	

You may send your contribution by fax to 905-451-1720  
 Or you can mail it to: 5-250 Clarence Street,  
 Brampton, ON L6W 1T4

If you have any questions, please call us at 905-451-1718, or e-mail us at [donor\\_relations@cmhapeel.ca](mailto:donor_relations@cmhapeel.ca) We will issue a tax receipt for donations of \$10 or more. Our charitable number is 12977 8882 RR0001