Dr Noble Irwin Regional Healthcare Foundation
2051 Saskatchewan Drive
Swift Current, Saskatchewan
S9H 0X6
306-778-3314
office@drirwinfoundation.com

Please complete the Pre-Authorized Debit (PAD) Plan Agreement below:

DONOR INFORMATION:

Name: _____

Address: _____

City / Town: _____ Province: _____

Postal Code: _____ Phone Number: _____

FINANCIAL INSTITUTION (FI) _____

Account | | | | | | | | | | | | Number: | | | | - | | | | | |
7 – 12 Digits Route Transit

Please Debit my bank account: $ _____

Frequency:

☐ Weekly ☐ Monthly ☐ Other: _____

Start Date: _____ _____ _____
Year Month Day

This donation is made on behalf of : ☐ Individual ☐ Business

I may revoke my authorization at any time, subject to providing notice of (*Payee to insert period – not to exceed 30 day).*

I/we authorize *Dr Noble Irwin Regional Healthcare Foundation*, and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our *Dr Noble Irwin Regional Healthcare Foundation* account(s). *Dr Noble Irwin Regional Healthcare Foundation* will provide annual written notice to the donor, to confirm the donor's continued support. This notice will be provided at least 10 days prior to the annual anniversary of this agreement.

This authority is to remain in effect until *Dr Noble Irwin Regional Healthcare Foundation* has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.
Dr Noble Irwin Regional Healthcare Foundation may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

Donor's Signature: _____ *Date:* _____