



# DONATION

**Please complete the secure form below to make your donation.  
All donations of \$2.00 and over are tax deductible**

## Personal Details

Title\_\_\_\_ Name \_\_\_\_\_ Surname \_\_\_\_\_  
Position (if applicable) \_\_\_\_\_  
Company (if applicable) \_\_\_\_\_  
Postal Address \_\_\_\_\_  
Town \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_  
Phone \_\_\_\_\_ Mobile \_\_\_\_\_  
Email \_\_\_\_\_

## Donation Details

Once       Monthly       Quarterly       Yearly  
 \$50       \$100       \$500       \$1000

Other Amount: \$ \_\_\_\_\_

## Credit Card Details

Mastercard       Visa  
Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Expiry Date \_\_\_\_ / \_\_\_\_  
Cardholder's Name \_\_\_\_\_  
  
Cardholder's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Direct deposit to our Bank of Queensland account:

Account Name:      Mackay Hospital Foundation  
BSB:                      124-049  
Account Number:      221 578 89  
Reference:              Your name or your organisation name

**I/We wish to direct our donation to:  
Please choose one option for your gift**

<input type="checkbox"/> Greatest Need	<input type="checkbox"/> Clinical area of choice (please specify) <hr/>
Hospital of choice (please indicate)	
<input type="checkbox"/> MACKAY <input type="checkbox"/> SARINA <input type="checkbox"/> PROSERPINE <input type="checkbox"/> MORANBAH <input type="checkbox"/> DYSART <input type="checkbox"/> CLERMONT	
<input type="checkbox"/> BOWEN <input type="checkbox"/> COLLINSVILLE	

- Please contact me, I wish to receive more information
- I would prefer that my gift remains anonymous
- Please send me information on making a gift in my will

**Mackay Hospital Foundation**

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**Thank you for supporting our local hospitals  
Your donation will make a difference**