MoCA
INSTITUT & CLINIQUE

Enregistrement No 81086 8844RR0001

MAKE A DONATION

Please fill the fields and print the document
Make sure to have filled all the obligatory fields preceded by an *

PERSONNAL INFORMATION OF DONOR

*Family Name: _____ *First Name: _____

* Adress: _____ * Apt: _____ * City: _____

* Postal code:_____* Province: _____ * Country: _____

* Email:_____ * Phone number: _____

UNIQUE DONATION

*Amount of contribution: ☐ 25$ ☐ 50$ ☐ 75$ ☐ 100$ ☐ other _____ **$**

MONTHLY DONATION

*I authorize MoCA Clinic & Institute to deduct every month on my credit card the amount of :

☐ 10$ ☐ 15$ ☐ 20$ ☐ Other _____$ (minimum 5.00$)

☐ 1st of each month ☐ 15 of each month ☐ Starting date (month/year): _____

TERMS OF PAYMENT

☐ Cheque (of name MoCA Clinic & Institute) ☐ Mastercard ☐ Visa ☐ cash

*Card No.: _____ *Expiration date: _____

* Signature: _____

* I wish to receive a receipt (donation of more than 20.00$): ☐ Yes ☐ No

* I accept that my name be published as a donator: ☐ Yes ☐ No

Thank you from team of MoCA Clinic & Institute

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