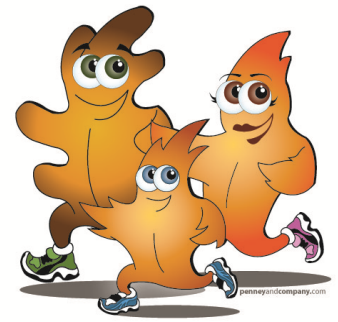


# Our Hospital Walk/Run



## Pledge Form

**YES! I want to do a little extra for my hospital.**

*In a heartbeat, you can make a difference. Together we can save and change lives. Your gifts to the NBRHC Foundation will ensure that the people of North Bay and area receive more advanced levels of care.*

**Thank you for your support!**

<b>Last Name:</b>		<b>First Name:</b>	
<b>Team Name:</b>			
<b>Mailing Address:</b>		<b>City:</b>	<b>Postal Code:</b>
<b>Email:</b>			
<b>Home Phone:</b>		<b>Business phone:</b>	

The pledge collector is responsible for all pledge collections. Receipts will be issued to donors who indicate " Receipt Required". Cheques should be made payable to North Bay Regional Health Center. For receipting purposes, please include all required information and print clearly.

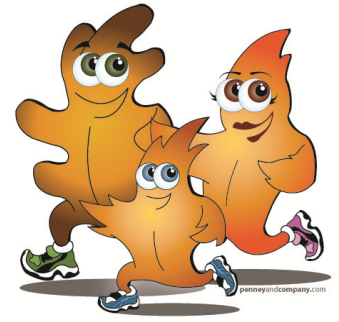
Name	Mailing Address	Postal Code	Telephone	Donation Amount
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
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				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
			Visa or MasterCard \$ Receipt Req. <input type="checkbox"/> ____/____/____ Exp. Date ____/____	
			Visa or MasterCard \$ Receipt Req. <input type="checkbox"/> <input type="checkbox"/> ____/____/____ Exp. Date ____/____	
<b>Closing our community's health care gap... Thank you for your gift!</b>			<b>TOTAL \$</b>	

For additional Pledge Forms please visit the NBRHC Foundation: 50 College Drive, North Bay 705-495-7562  
OR visit [www.ourhospitalwalkrun.ca](http://www.ourhospitalwalkrun.ca) to print extra forms as needed.

Charitable No. BN88773 1123 RR0001

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Name	Mailing Address	Postal Code	Telephone	Donation Amount
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
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				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
			Visa or MasterCard \$ _____ _____ / _____ / _____ Exp. Date ____/____/____	Receipt Req. <input type="checkbox"/>
			Visa or MasterCard \$ _____ _____ / _____ / _____ Exp. Date ____/____/____	Receipt Req. <input type="checkbox"/>
Closing our community's health care gap... Thank you for your gift!			<b>TOTAL \$</b>	

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