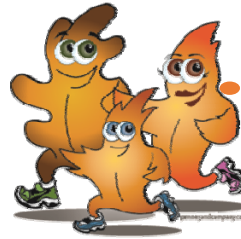


Our Hospital Walk/Run



ourhospitalwalkrun.ca

**Raise \$80 and
your race fee
is FREE!**

Pledge Form

YES! I want to support my hospital!

Funds raised through Our Hospital Walk/Run helps North Bay Regional Health Centre provide advanced levels of care, expand services, improve and develop new programs, and bring leading-edge medical technology to our community.

Thank you for your generosity!

Last Name:		First Name:	
Team Name:			
Mailing Address:		City:	Postal Code:
Email:			
Home Phone:		Business phone:	

The pledge collector is responsible for all pledge collections. Receipts will be issued to donors who indicate "☑ Receipt Required".
Make cheques payable to NBRHC Foundation. 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"/>
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
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			Visa or MasterCard \$ Receipt Req. <input type="checkbox"/> ____ / ____ / ____ / ____ Exp. Date ____ / ____	
			Visa or MasterCard \$ Receipt Req. <input type="checkbox"/> <input type="checkbox"/> ____ / ____ / ____ / ____ Exp. Date ____ / ____	
Enhancing your healthcare, close to home. Thank you for your gift!			TOTAL \$	

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

Charitable No. BN88773 1123 RR0001

Name	Mailing Address	Postal Code	Telephone	Donation Amount
				\$ Paid <input type="checkbox"/> Receipt Req. <input type="checkbox"/>
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			Visa or MasterCard \$ _____ / _____ / _____ / _____ Exp. Date ____ / ____	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"/>
			Visa or MasterCard \$ _____ / _____ / _____ / _____ Exp. Date ____ / ____	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"/>
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North Bay
Regional Health
Centre Foundation



Fondation du Centre
régional de santé
de North Bay

