



DONATION FORM

I / We wish to support your work and make a donation to:-

- St. Andrew's Mission Hospital**
- St. Andrew's Community Hospital**
- St. Andrew's Autism Centre**
- St. Andrew's Senior Care** (JOY Connect* / Tampines* / Henderson* / Queenstown*)
- St. Andrew's Nursing Home** (Buangkok* / Henderson* / Queenstown*)

(*You may circle your choice)

1. By Cheque:-

Amount: S\$ _____ (Bank and Cheque No. : _____)

Please issue your cheque payable to the service which you would like to support. On the reverse side of the cheque, please include your full name or company name, NRIC/FIN/ROB/ROC/UEN no., and contact number.

2. By Credit Card:-

- One-time donation
- Monthly donation, from _____ (month/year) to _____ (month/year)

Credit Card no.: _____ (Visa / MasterCard / AMEX)

Amount: S\$ _____ Name of Bank: _____ Card expiry date: _____

Signature: _____

3. By GIRO Deduction:- (Authorisation form on next page)

Donations of S\$50 or more may be eligible for 250% tax deduction. Tax deductions will be automatically reflected in your annual tax assessments. To qualify for tax deduction, please provide your full name and NRIC/FIN/UEN number.

Receipts will only be given for donations of \$500 and above. For donations below \$500, receipts will be given upon request.

All donors who gave S\$500 or more will be acknowledged in the St. Andrew's Mission Hospital Annual Report, unless indicated otherwise.

To St. Andrew's Mission Hospital:

- I do not require tax deduction.
- I wish to receive a receipt.
- I do not wish to be acknowledged for my donation.

DONOR'S PARTICULARS

(Dr. / Mr. / Mrs. / Miss/ Mdm. / Ms. / _____):

Name of Person or Company: _____

NRIC / FIN / ROB / ROC / UEN no.: _____

Mailing address: _____ Postal Code: _____

Email: _____ Contact no.: _____

Please mail form (and cheque) to: **St. Andrew's Mission Hospital, 8 Simei Street 3, Singapore 529895**

Thank you for your donation and support

Donation to St. Andrew's Mission Hospital via GIRO Deduction

To (Name of Bank):

Branch:

Name of Account Holder:

Bank Account Number:

Donation Amount: S\$_____ Monthly deduction from _____ (mth/yr) to _____ (mth/yr)

Name of Billing Organisation: **St. Andrew's Mission Hospital**

- I/We hereby instruct you to process St. Andrew's Mission Hospital instructions to debit my/our account.
- You are entitled to reject St. Andrew's Mission Hospital debit instructions if my/our account does not have sufficient funds and charge me/us a fee for this. You may also at your discretion allow the debit even if this results in an overdraft on the account and impose charges accordingly.
- This authorisation will remain in force per the duration period indicated above, or until it is terminated by your written notice sent to my/our address last known to you, or upon receipt of my/our written revocation through St. Andrew's Mission Hospital.

 Thumb print(s) / Signature(s) as in bank record
 (Please go to the branch with your identification for thumbprint)

 Date

For St. Andrew's Mission Hospital Use Only:

Bank	Branch	St. Andrew's Mission Hospital A/C No.
7 1 7 1	0 0 3	0 0 3 9 0 3 0 8 5 1

St. Andrew's Mission Hospital Donor Ref. No.

For Bank's Official Use Only:

To: St. Andrew's Mission Hospital
 This application is hereby APPROVED / REJECTED*. [Please tick the following reason(s):]

- Signature / thumbprint* differs from financial institution's records.
- Signature / thumbprint* incomplete / unclear*
- Account operated by signature / thumbprint*
- Amendments not countersigned by customer
- Wrong account number
- Others: _____

(* Please delete where applicable)

 Name of approving officer

 Signature

 Date