EMMANUEL HOSPITAL ASSOCIATION
CANADA

Pre-Authorized Debit Plan (PAD)

Name_____

Address_____

_____

Phone_____

Email Address_____

Financial Institute_____

Address _____

Account#_____

1. I have attached a blank cheque marked "VOID"
2. I hereby authorize EHA (Canada) to withdraw a regular monthly gift of $_____ on the 15th day of each month beginning Month of _____ Year_____.
3. I agree that any information contained in this Authorization may be disclosed to the Royal Bank of Canada as required to complete any PAD transactions.

Signature_____

Date_____

Please forward with blank void cheque to:

EHA Canada
8-115 Meadows Blvd
Saskatoon, SK
S7V 0E6

-