



CMAT use only:
Profile#: _____

Canadian Medical Assistance Teams Manual Donation Form

Mail to:
CMAT
150 Brant Avenue.
Brantford, ON. N3T 3H7 Canada

Fax to:
Local Fax: 519.720.0282
Toll Free Fax: 1.866.670.0167

DONOR INFORMATION: Title: Mr. Mrs. Ms. Dr. Other: _____

First Name: Last Name:

Address:

City: Prov./ State:

Country: Postal/ Zip:

Primary Ph: () Secondary Ph: ()

Email:

May we update you by email to save costs? Yes No
Please send my charitable receipt by: Email Post Fax: ()

Payment Method:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Card Number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Expiry Date:	Month: <input type="text"/> Year: <input type="text"/>
Donation Amount:	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$250 <input type="checkbox"/> \$100 <input type="checkbox"/> \$50 <input type="checkbox"/> \$25 <input type="checkbox"/> Other amount: <input type="text"/> Currency: <input type="checkbox"/> CAD <input type="checkbox"/> USD
	<p>IMPORTANT NOTE TO THOSE DONATING IN \$USD: \$USD donations will be converted to Canadian funds. Some banks charge a conversion fee. Please check with your bank or credit card company.</p>
Country to Assist:	<input type="text"/>
CMAT Team member to support:	Enter the volunteer's name here if this donation is to support his/ her airfare expense: <input type="text"/>
Where would you like your donation to go?	<input type="checkbox"/> Where needed most <input type="checkbox"/> Other: <input type="text"/>
Donor Signature:	Date: / / .