Dr Noble Irwin Healthcare Foundation
2051 Saskatchewan Dr
Swift Current, SK
S9H 0X6
(306) 778-3314

Please complete the Pre-Authorized Debit (PAD) Plan Agreement below:

DONOR INFORMATION:

Name: _____

Address: _____

City / Town: _____ Province: _____

Postal Code: _____ Phone Number: _____

FINANCIAL INSTITUTION (FI) _____

Account [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] Number: [ ][ ][ ] - [ ][ ][ ][ ][ ]

7 – 12 Digits Route Transit

Please Debit my bank account: $ _____

Frequency:

☐ Annually ☐ Monthly

Start Date: _____ _____ _____

Year Month Day

This donation is made on behalf of : ☐ Individual ☐ Business

I may revoke my authorization at any time, subject to providing notice of (Payee to insert period – not to exceed 30 day).

I/we authorize Dr Noble Irwin Healthcare Foundation, and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our Dr Noble Irwin Healthcare Foundation account(s). Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the 5th day of each month. Dr Noble Irwin Healthcare Foundation will provide 10 days written notice of the amount of each regular debit. Dr Noble Irwin Healthcare Foundation will obtain my/our authorization for any other one-time or sporadic debits.

This authority is to remain in effect until Dr Noble Irwin Healthcare Foundation has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.
Dr Noble Irwin Healthcare Foundation may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

Donor's Signature: _____ *Date:* _____