



## DONATION FORM

I/ We would like to make a donation to (please tick your choice):

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

(\*Please circle)

### DONATION AMOUNT

- S\$50       S\$100       S\$500       S\$1,000       Others: S\$ \_\_\_\_\_

### MODE OF DONATION

• **Cheque:**

Cheque No.: \_\_\_\_\_ (Please issue cheque payable to: **St. Andrew's Mission Hospital**)

• **Credit Card:**

One-time donation       Monthly donation: From \_\_\_\_/\_\_\_\_ (mm/yy) to \_\_\_\_/\_\_\_\_ (mm/yy)  
Credit Card No.: \_\_\_\_\_ VISA / Mastercard / AMEX (Please circle) Expiry Date: \_\_\_\_/\_\_\_\_ (mm/yy)

• **Online via Giving.sg:**



[www.giving.sg/st-andrew-s-mission-hospital](http://www.giving.sg/st-andrew-s-mission-hospital)

• **GIRO:**

Please referred to the Authorisation Form on the next page.

### DONOR'S PARTICULARS

Name / Company Name: (Mr. / Mrs. / Miss. / Ms. / Mdm. / Dr. / \_\_\_\_)

NRIC / FIN / UEN No.: \_\_\_\_\_ (required for tax rebate)

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Contact No.: \_\_\_\_\_

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

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

All donors who give S\$1000 or more will be acknowledged in the St. Andrew's Mission Hospital Annual Report(s), unless otherwise indicated.

- I do not require tax deduction.       I wish to receive a receipt.  
 I do not wish to be acknowledged in the SAMH Annual Report.

**Please mail the form to St. Andrew's Mission Hospital, 8 Simei Street 3, Singapore 529895**

***Thank you for your donation and support***

By submitting this donation form, you fully understand and agree to SAMH's use and disclosure of your personal data for the purposes of donation-processing as well as fundraising related activities, including carrying out fundraising updates, appeals and events, and the submission of donation data to the Inland Revenue Authority of Singapore (IRAS) for tax-deduction purposes. SAMH aim to comply with the requirements of the Personal Data Protection Act 2012 and apply its obligations to our processes to safeguard your personal data.

**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: _____ / _____ (mm/yy) to _____ / _____ (mm/yy)

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.

\_\_\_\_\_  
Signature(s) / Thumb print(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

**Please mail the form to St. Andrew's Mission Hospital, 8 Simei Street 3, Singapore 529895**

***Thank you for your donation and support***