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 Mission School
☐ St. Andrew's Migrant Worker Medical Centre
☐ St. Andrew's Nursing Home (○Aljunied / ○Buangkok / ○Henderson / ○Queenstown / ○Tampines North)
☐ St. John's - St. Margaret's Nursing Home
☐ St. Andrew's Senior Care (○Dover / ○Henderson / ○JOY Connect / ○Queenstown / ○Tampines Central / ○Tampines North)
☐ St. Andrew's Active Ageing Centre (Care) (○Bedok North / ○Bedok South / ○Dover)

DONATION AMOUNT

☐ S$50 ☐ S$100 ☐S$500 ☐S$1,000 ☐Others: S$ _____

MODE OF DONATION **Please do not staple your cheque or enclose cash.**

- **Cheque:**
  Cheque No.: _____(Please issue cheque payable to: **St. Andrew's Mission Hospital**)
- **Credit Card (Mastercard / Visa / Amex):**
  ☐One-time donation ☐Monthly donation: From _____/_____(mm/yy) to _____/_____(mm/yy)
  Credit Card No.: _____ Expiry Date: _____/_____(mm/yy)
- **Online via Giving.sg:**
  www.giving.sg/st-andrew-s-mission-hospital
- **GIRO:**
  Please use the Authorisation Form on the next page.

DONOR'S PARTICULARS

Name / Company Name: (Mr. / Mrs. / Miss / Ms. / Mdm. / Dr. / ____) _____
Full NRIC / FIN / UEN No.: _____**(*REQUIRED FOR TAX DEDUCTION)**
Address: _____Postal Code: _____
Email: _____Contact No.: _____

St. Andrew's Mission Hospital (SAMH) is an Institution of a Public Character. All donations are eligible for 2.5 times tax deduction. To qualify for tax deduction, please provide your full name / company name and NRIC / FIN / UEN number. Tax deduction will automatically be reflected in your annual tax assessment.

☐Please tick the box if you wish to receive a receipt.

☐Please tick the box if you wish to be acknowledged in the SAMH Annual Report.

Please mail the form to: **St. Andrew's Mission Hospital, 10 Simei Street 3 Singapore 529897, Group Corporate Communications Department**

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

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

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

_____ _____

Signature(s) / Thumb print(s)* as in bank record Date

(* Please go to the branch with your identification for thumbprint)

For St. Andrew's Mission Hospital's 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.											
S	A	M	H								

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, 10 Simei Street 3 Singapore 529897, Group Corporate Communications Department**

Thank you for your donation and support!