Automatic Monthly Withdrawal Authorization Form

Section 1: Gift Amount

Annual Fund $_____ Per Month

In Honor or Memory **(please circle)** of: _____

Please notify: Name: _____

Address: _____

City, State, Zip: _____

Section 2: Authorization for Automatic Monthly Withdrawal / Charge

Start Date: (MM/YY)_____/_____ For **ONE Year**

☐ Bank Withdrawal OR ☐ Credit/Debit Card

Type of account: ☐ Checking ☐ Savings

Type of Card (Visa/M.C./Amex/Discover)

Bank Name: _____

Name on Card: _____

Routing # (9 Digits): _____

Card No: _____

Account # (10 Digits): _____

Expiration Date: _____ CVV: _____

Sign here: _____

If withdrawal is from Checking Account, please attach a copy of a voided check.

Section 3: Contact Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

☐ Yes, Please Recognize My Gift as a Member of the Compassionate Champions Club in the Foundation's Various Supporter Honor Rolls

I hereby authorize Oncology Nursing Foundation to make monthly withdrawals in the amount listed above. It is understood that this agreement may be terminated by me at any time by written notification to the Oncology Nursing Foundation.

Return to:

Oncology Nursing Foundation

By secure fax: 412-774-2937

By secure email using http://sendthisfile.com/ons email to financeteamshared@ons.org

The Oncology Nursing Foundation is a 501 (c)(3) charitable organization. No goods or services were given in exchange for this donation.