Automatic Monthly Withdrawal Authorization Form

Section 1: Gift Amount

Sustaining Impact Fund $_____Per Month

Annual Fund $_____Per Month

☐ In Honor or ☐ In Memory of: _____

Please notify: Name: _____

Address:_____

City, State, Zip: _____

Section 2: Authorization for Automatic Monthly Withdrawal / Charge

Start Date: (MM/YY)_____/_____ Please Check one: ☐ **ONE Year** ☐ **TWO Years**

☐ 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 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.