



Thank you for your support!

Amount \$ _____

Personal Information

Name _____

Address _____

City _____

Province/State _____

Postal Code/Zip _____

E-mail Address _____

Telephone Number _____

Payment Information

Payment Method Visa Mastercard

Name on Card _____

Credit Card Number _____

Expiry Date _____ (Month/Year)

In Memoriam Yes No

If yes, please fill out the information below:

Name of Person _____

Address of Family _____

City: _____

Province/State: _____

Postal Code/ZIP: _____

Contact Information

Meningitis Research Foundation of Canada
P.O. Box 28015 R.P.O. Parkdale
Waterloo, Ontario N2L 6J8

Phone or Fax - (519) 664-0244

Toll-free 1-800-643-1303

E-mail - fund@meningitis.ca

Charitable Registration #
89751 8429 RR0001

Payroll Deductions

Yes No

If yes, please fill out the information below,
print and give to your employer.

Amount Deducted from Pay: _____

Legal Company Name:

Address: _____

City: _____

Province/State: _____

Postal Code/ZIP: _____

Telephone: _____ Ext _____

Contact (Payroll) E-mail Address:

Fax: _____

Company Web Site:

Comments

