



Pre-Authorized Debit (PAD) Agreement

INTERNATIONAL MEDICAL HEALTH ORGANIZATION (IMHO) CANADA

I want to support the International Medical Health Organization (IMHO) Canada through monthly contributions.

Please debit my bank account: (Void Cheque Attached)

___\$10 ___\$20 ___\$25 ___\$50 ___\$75 ___\$100 Other Amount___ (specify)

The debit will be processed from the specified account on the 15th of each month or the next business day.

This donation is made on behalf of: _____an individual or _____a business

I may revoke my authorization at any time, subject to providing notice of period not exceeding THIRTY (30) days. To obtain a sample cancellation form, or for more information on my right to cancel a PAD agreement, I may contact the financial institution or visit www.cdnpay.ca.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on my recourse right, I may contact my financial institution or visit www.cdnpay.ca.

Donor Name: _____

Address / Contact Information: _____

Telephone No: _____

Email: _____

Signature: _____

Completed Form Should Be Mailed To:

**The Treasurer
IMHO Canada
5637 Finch Ave. East, Unit #7
Toronto, ON
M1B 2T9**

E-Mail: contact@imhocanada.org

Tel.: 416 321 9555

Web: www.imhocanada.org

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