



# Medical Services Monthly Donation Scheme

## Donation Form

Please return the completed form by fax to 2559 6835 or by post to Tung Wah Group of Hospitals, Freepost No. 10 (No stamp required if post within Hong Kong).  
(Please "✓" or delete as appropriate)

### Donation Information

☐ **Yes! I/We would like to support Medical Services Monthly Donation Scheme to provide continuous support to Tung Wah's medical and health care services, and make a monthly donation of:**

☐ HK\$1,000 ☐ HK\$500 ☐ HK\$300 ☐ HK\$200 ☐ HK\$ \_\_\_\_\_

or ☐ I/We would like to make a one-off donation of:

☐ HK\$1,200 ☐ HK\$800 ☐ HK\$500 ☐ HK\$300 ☐ HK\$ \_\_\_\_\_

The above donation is made for:

- ☐ Free medical services  
☐ Expensive medical consumables for needy patients  
☐ Patient assistance funds  
☐ Enhancement of medical facilities

### Online Donation (For credit card donation ONLY)

You can use your credit card to make donation at our website : [www.tungwah.org.hk](http://www.tungwah.org.hk) or scan the QR code (right). You are not required to return this form to Tung Wah. Receipts will be issued according to the information you provide via online.



### Personal Information

Name of Donor: \_\_\_\_\_ Mr./Ms.

Address: \_\_\_\_\_

Daytime Tel. No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (DD/MM)

E-mail: \_\_\_\_\_

Message from Donor: \_\_\_\_\_

### Payment Method

#### ☐ Donation by Cheque (For one-off donation)

Cheque no.: \_\_\_\_\_  
(Please make your crossed cheque payable to "Tung Wah Group of Hospitals" and mail to us with this completed form for a donation receipt.)

#### ☐ Payment by Credit Card <sup>Remark 2</sup> (For monthly and/or one-off donation)

☐ VISA ☐ MasterCard

Card number: \_\_\_\_\_

Card valid until: \_\_\_\_\_ MM/ \_\_\_\_\_ YY

Cardholder's name: \_\_\_\_\_ Mr./Ms.

Signature of cardholder: \_\_\_\_\_

Date: \_\_\_\_\_

- Please ensure that the signature used is the same as that on your credit card, and **sign all amendments in the same way.**
- I/We hereby authorize Tung Wah Group of Hospitals to charge my/our card account for the relevant amounts specified above. This authorization shall have effect until further notice. I/We agree that this authorization shall have effect after the valid date of the credit card or replacement of the credit card, and no authorization form will be submitted again. I/We agree that any notice of cancellation or variation of this authorization shall be given at seven working days before such cancellation/variation is to take effect.
- If you submit this authorization form by fax, you are not required to mail this form to Tung Wah again.

#### ☐ Bank Monthly Direct Debit Authorization Form <sup>Remark 2</sup>

(For monthly donation ONLY; **only original is accepted, any alteration requires signature.**)

Name of Party to be credited (The Beneficiary)

**TUNG WAH GROUP OF HOSPITALS**

Bank No. Branch No. Account No. to be credited

0 | 0 | 4 | 0 | 0 | 2 | 2 | 5 | 0 | 5 | 5 | 3 | 0 | 0 | 1

My / Our Bank Name and Branch

Bank No. Branch No. My / Our Account No.

My / Our Name as recorded on Statement/Passbook

My / Our Hong Kong Identity Card No./ Passport No.

My / Our Signature(s) (Same as the signature(s) of your bank account)

Date

Donor No. (To be filled in by TWGHs)

- I/We hereby authorize my/our above named Bank to effect transfer from my/our account to that of the above named beneficiary in accordance with such instructions as my/our Bank may receive from the beneficiary from time to time.
- I/We agree that my/our Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.
- I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our account which may arise as a result of any such transfer(s).
- I/We agree that should there be insufficient funds in my/our account to meet any transfer hereby authorized, my/our Bank shall be entitled, in its discretion, not to effect such transfer in which event the Bank may make the usual charge.
- I/We agree that any notice of cancellation or variation of this authorization which I/we may give to my/our Bank shall be given at least two working days prior to the date on which such cancellation/variation is to take effect and at the same time such notice shall be given to the beneficiary.
- I/We confirm my/our signature(s) on this form is/are the same as the signature(s) of my/our Bank account given above. Until further notice, I/We hereby authorize Tung Wah Group of Hospitals to initiate and the Bank named above to process debits to my/our account from time to time.

### Donation Receipt

☐ Please issue donation receipt <sup>Remark 1</sup>

Name on receipt: \_\_\_\_\_ Mr./Ms.

(if different from donor's name)

For monthly donations, an annual receipt will be issued in April to help you pursue your tax return.

☐ To help save administrative costs, please do not send me a donation receipt.

#### Remarks

- Donation of \$100 or more to Tung Wah is tax deductible.
- Autopay transaction will be processed within the first week of the month.
- Please call the Fund-raising Division of Tung Wah Group of Hospitals at 1878 333 or 2859 7419 for details.
- Your personal data will be used for issuance of receipt and fund-raising purposes only. If you do not wish to receive future mailings from Tung Wah Group of Hospitals, please advise us in writing. No handling fee will be charged.



#### FOR TWGHs USE

Received on		Receipt issued on	
Receipt no.	R	Receipt/TYL sent on	
Donation A/C name	FMD	Amount (HK\$)	