CANADIAN FILM CENTRE | DONATION FORM

CONTAC	CT INFORMA	TION			
TITLE:	MR.	MRS.	MS.	DR.	OTHER
NAME					
ADDRESS			ΓΥ	PROVINCE	POSTAL CODE
TELEPHON	IE	EN	1AIL		
I would	like to mak	e a donatior	n in the a	imount of:	
\$2	\$25,000		\$10,000		\$5,000
\$1,000		\$5	\$500		\$250
OTHER \$	· 				
PAYMENT VISA MASTERCARE		ASTERCARD	CHEQUE (PAYABLE TO CANADIAN FILM CENTRE)		
CARD NUM	ИBER				
EXPIRATION DATE			CVV C	ODE	
NAME ON	CARD				
SIGNATUR	 E			DATE	

A tax receipt will be issued for donations of \$20 or more. Charitable Registration #: 10684-4251-RR0001

THANK YOU FOR YOUR SUPPORT!



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