



PLEDGE FORM

PARTICIPANT or TEAM NAME		DATE	
ADDRESS	CITY/PROV	POSTAL CODE	
PHONE	EMAIL		

<i>PLEASE MAKE CHEQUES PAYABLE TO CROSSROADS CLINIC. DONATIONS \$20 AND OVER WILL RECEIVE A TAX RECEIPT WITH COMPLETE NAME & ADDRESS.</i>				AMOUNT COLLECTED
NAME	PHONE			<input type="checkbox"/> CASH <input type="checkbox"/> CHEQUE
ADDRESS	CITY	PROVINCE	POSTAL CODE	
EMAIL				
<input type="checkbox"/> PLEASE DO NOT ADD ME TO MAILING LIST				<input type="checkbox"/> NO TAX RECEIPT PLEASE
NAME	PHONE			<input type="checkbox"/> CASH <input type="checkbox"/> CHEQUE
ADDRESS	CITY	PROVINCE	POSTAL CODE	
EMAIL				
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PAGE ____ OF ____	PAGE TOTAL	
TOTAL SUBMITTED		