



CYSTIC FIBROSIS NEW SOUTH WALES

PO BOX 149 NORTH RYDE NSW 1670
(51 Wicks Road, NORTH RYDE NSW 2113)

Yes! I will become a Cystic Fibrosis NSW partner by making a monthly contribution.

Surname: _____

Given Names: _____

Address: _____

_____ **State:** _____ **Postcode:** _____

Contact Number: _____ **e-mail address:** _____

Cardholder Details

(Please Circle) MasterCard Visa AMEX

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Expiry Date: _____ / _____ **Name on the Card:** _____

Donation Details

Donation amount:

\$20 per month \$30 per month \$40 per month my choice \$_____ per month

Donations will be debited from your card on the second Tuesday of the month.

I wish to use my credit card to make a regular donation to Cystic Fibrosis New South Wales.

I hereby authorise Cystic Fibrosis New South Wales to debit my credit card monthly with the amount specified above.

This authority shall stand, in respect of the specified card and in respect of any card issued to me in renewal or replacement thereof, until I notify Cystic Fibrosis New South Wales in writing of its cancellation.

Cardholder's Signature: _____ **Date:** _____ / _____ / _____

_____ **Date Received:** _____ / _____ / _____ **Office Use** **Date Processed:** _____ / _____ / _____

Donor Number: _____