



**Sanctuary Mental Health Society**  
**Pre-Authorized Debit (PAD) Authorization Form**

**I WANT TO SUPPORT SANCTUARY MENTAL HEALTH SOCIETY THROUGH MONTHLY DONATIONS.**

**Please debit my bank account: (please attach VOID cheque)**

**\_\_\_ \$50 \_\_\_ \$100 \_\_\_ \$200 Other Amount \$\_\_\_\_\_ (specify)**

The debit will be processed to your account on the 15<sup>th</sup> day of each month or the next business day. Donations to start \_\_\_\_\_ and every 15<sup>th</sup> of the month (or next business day) thereafter.

Signature: \_\_\_\_\_

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

Donor name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

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

**This donation is made on behalf of \_\_\_\_\_ an Individual \_\_\_\_\_ a Business**

**Please mail this form along with a void cheque to:**

Sanctuary Mental Health Society  
Second Floor - 107 E 3rd Avenue  
Vancouver, BC V5T 1C7

E-mail: [info@sanctuarymentalhealth.org](mailto:info@sanctuarymentalhealth.org) | Phone: 778-836-HOPE (4673)

I may revoke my authorization at any time upon written notification to Sanctuary Mental Health Ministries, subject to at least 2 weeks' notice prior to the next scheduled PAD. I understand that it will take at least 2 weeks before automatic deductions can begin. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit [www.cdnpay.ca](http://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 rights, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).