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Donation Form

Please accept my donation of the below amount to assist Cohuna District Hospital:

☐ $20 ☐ $50 ☐ $100 ☐ $200 ☐ $500 ☐ $1,000

☐ Other $ _____ Receipt required: Y (complete Personal Details) / N

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Please charge my ☐ Mastercard ☐ Visa the amount of $_____

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