



First and last names: _____

Address: _____

City Town: _____ Postal code: _____

Province: _____ Country: _____

Phone: _____ Fax: _____

Email address: _____ Cell: _____

MY DONATION –

I would like to give you on a monthly basis

Each month, please debit my account on the 1st or 3rd Wednesday (please tick one box)

*Please increase my donation annually by or

DEBIT ORDER (OPTION #1) –

Account type – Savings Current Transmission

Name of bank: _____

Name of card or account holder: _____

Account number: _____

Branch name: _____

Branch code: _____

CARD DONATION (OPTION #2) –

Account type – VISA MasterCard American Express

Card holder name: _____

Card number: _____ Last 3 security numbers of back of card: _____

Expiry date: _____ Month: _____ Year: _____

I hereby request and authorise Medecins Sans Frontieres South Africa to draw against my account with the abovementioned bank (or any other bank or branch to which I may transfer my/our account) the sum of the above amount each and every month on the day indicated above. All such withdrawals from my bank account by Medecins Sans Frontieres South Africa shall be treated as though I had signed them personally.

I understand that the withdrawals hereby authorised will be processed by Medecins Sans Frontieres South Africa and the details of each withdrawal will be printed on my account statement or on an accompanying voucher. I agree to pay any bank charges relating to this debit order instruction. This authority may be cancelled by me by giving Medecins Sans Frontieres South Africa thirty days notice in writing, sent by prepaid registered post, but I understand that I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force if such amounts were legally owing to you.

Signed at _____ On this _____ Day of _____ 20 _____

Authorised signature: _____