



Southlake Regional Health Centre Foundation  
 615 Davis Drive, Suite 304  
 Newmarket, Ontario L3Y 2R2  
 T: 905-836-7333 F: 905-836-5651  
 Toll free: 1-877-457-2036  
 www.southlakeregional.org  
 Charitable business number: 13179 7540 RR0001

### Gift of Publicly Traded Securities to Southlake Regional Health Centre Foundation

To initiate your gift of securities transfer, please complete this form to send to your broker and return a copy by fax to the Foundation office at Southlake to the attention of Dora Boylen-Pabst, Philanthropic Giving Director. Your broker will be able to provide certain information such as the CUSIP and FINS numbers.

Unexpected and/or unidentified transfers may make it difficult for the Foundation to issue the appropriate donation receipt. Please contact Dora Boylen-Pabst, Philanthropic Giving Director, with any questions you may have about the gift of securities transfer process. In all cases, the gift receipt will reflect the actual sale price of the securities (average of high and low on the day transferred).

Your broker may contact **Account Transfers Dept.** (416) 359-5754 at BMO Nesbitt Burns with any questions.

To: \_\_\_\_\_  
 Name of Brokerage/Delivering Institution

Attention: \_\_\_\_\_  
 Name of Contact person at Brokerage/Delivering Institution

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Client Account number: \_\_\_\_\_

#### Instructions to Broker/Delivering Institution

I hereby give authority to deliver free the following securities to BMO Nesbitt Inc. (Fins# T009 , CUIDS: NTDT , DTC: 5043) for credit to account# 656-01562-15 Southlake Regional Health Centre Foundation. **Please deliver free of transfer fees:**

Security: \_\_\_\_\_ CUSIP# \_\_\_\_\_

Market Symbol: \_\_\_\_\_ Number of Shares/Units to transfer: \_\_\_\_\_

#### Donor/Client Information

Name of donor/client for charitable receiving purposes (please print):  
 \_\_\_\_\_

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

Main Telephone Number: \_\_\_\_\_

#### Gift Designation

- Southlake Regional Health Centre Priority Needs
- Other: \_\_\_\_\_  
 (please specify)

#### Authorization of Donor(s)/Client(s)

\_\_\_\_\_  
 Signature day / month / year

\_\_\_\_\_  
 Signature day / month / year

\_\_\_\_\_  
 Witness to signature(s) day / month / year

\_\_\_\_\_  
 Witness Name (please print) day / month / year