



DeafBlind
ONTARIO SERVICES

FRIENDS WITH VISION

Monthly Giving Program

An easy and consistent way to give! Donors receive annual tax receipts and are kept up-to-date on the latest news and events in the organization.

*"It's in honour of my brother and my parents' "vision" that I'm a **Friend with Vision** & donate monthly."*



deafblindontario.com

*"I've been a monthly donor for some time now. When I think about it, it's the word "vision" in **Friends with Vision** that means a lot to me.*

My brother, Sean, was one of the earliest to benefit from the "vision" that started with a dedicated group of parents whose children were deafblind. That group included my own parents.

In the beginning, these parents worked tirelessly to get housing, support and programming for Sean and his friends, and started this amazing organization.

Since then, DeafBlind Ontario Services' clients enjoy a better quality of life with dignity and purpose. Each person can reach their potential and be active in the community.

Sean is no longer with us, but his legacy and my parents' "vision" lives on today in the work of

DeafBlind Ontario Services.

*It's in honour of my brother and my parents' "vision" that I'm a **Friend with Vision** and donate monthly.*

Having a regular monthly revenue lets DeafBlind Ontario Services plan for the future.

*My daughter, Jennifer, is also a **Friend with Vision** to honour her uncle Sean.*



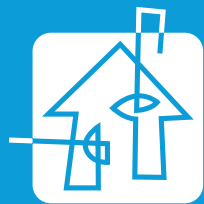
I'm proud... my family's proud... to be a part of an organization that's looking to the future,

with vision and purpose.

*Please become a **Friend with Vision** today. It's so easy, convenient and secure. And, best of all, you'll truly make a difference.*

Thank you from Sean's family."

Karen Becker



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**I wish to designate my
gift to:**

- ☐ Where it's needed
most
- ☐ Accessibility
- ☐ Client Experiences
- ☐ Nicaragua Project

Charitable Registration
Number:
13183-4319-RR0001



deafblindontario.com

**Yes, I want to become a
“FRIEND WITH VISION”!**

Name: _____

Mailing Address (for tax receipt): _____

Phone Number: _____

Email Address: _____

Payment Information ☐ Credit Card

Name on Card: _____

Credit Card Number: _____

Expiry: _____

Signature: _____

☐ Please charge my credit card the following
amount each month: _____

Please charge my card on (check one):

1st of month ☐ **OR** ☐ **15th of the month**

☐ **Post-dated Cheque (Payable to DeafBlind Ontario
Services)**

Please return this form to DeafBlind Ontario Services
at 17665 Leslie Street, Unit 15, Newmarket, Ontario
L3Y 3E3 or by email to development@deafblindontario.com