

# Employee Giving Program

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

Name: \_\_\_\_\_ Employee ID Number: \_\_\_\_\_

Department: \_\_\_\_\_ Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Yes! I would like to make a gift to Methodist Hospitals' programs through the employee giving program.

Please select your payment method and gift level.

**Payroll Deduction** - Complete the front and back of this form and return it to the Foundation Office.

**Payroll Deduction Examples:**

- \$1 per Pay Period (\$26 per year)
- \$5 per Pay Period (\$130 per year)
- \$10 per Pay Period (\$260 per year)
- \$25 per Pay Period (\$650 per year)
- \$40 per Pay Period (\$1,040 per year)
- \_\_\_ Your Preferred Amount (Amount x 26 = \$\_\_\_\_\_ per year)

**Credit Card** - I want to make a one-time contribution by credit card in the amount of \$\_\_\_\_\_

Check One:  Visa  MasterCard  AmEx  Discover

Name: \_\_\_\_\_

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Today's Date: \_\_\_\_\_

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

**Check/Cash** - I want to make a one-time contribution in the amount of \$\_\_\_\_\_

Check One: \$\_\_\_\_\_ Cash \$\_\_\_\_\_ Check / #\_\_\_\_\_

**I wish to designate my donation as follows:**

- \_\_\_ Area of Greatest Need
- \_\_\_ Breast Health Care
- \_\_\_ Heart & Vascular Care
- \_\_\_ Neuroscience & Neurology Care
- \_\_\_ Nursing at Methodist
- \_\_\_ Oncology Care
- \_\_\_ Orthopedic & Spine Care
- \_\_\_ Methodist Family Angel Network\*
- \_\_\_ Other (Please Specify)

\*As part of the "Everyone Matters" Employee Giving Program, you may choose to support your co-workers during a time of personal need by making a donation.

# Payroll Deduction Authorization

## “Everyone Matters” Employee Giving Commitment

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

Name: \_\_\_\_\_ Employee ID Number: \_\_\_\_\_

Department: \_\_\_\_\_ Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Yes! I would like to make a gift to Methodist Hospitals' programs through the employee giving program.

Please select your payroll / gift level.

- \$1 per Pay Period (\$26 per year)
- \$5 per Pay Period (\$130 per year)
- \$10 per Pay Period (\$260 per year)
- \$25 per Pay Period (\$650 per year)
- \$40 per Pay Period (\$1,040 per year)
- Your Preferred Amount (Amount x 26 = \$\_\_\_\_\_ per year)

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I hereby authorize the payroll deduction as indicated above and on the reverse side of this form for the Everyone Matters Employee Giving Program. I understand that this form constitutes a declaration of my intent to pay and may be revised upon request if my circumstances change or if I instruct otherwise.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Methodist Hospitals Foundation Executive Director \_\_\_\_\_ Date \_\_\_\_\_

