French Hospital Medical Center
Employee Giving Campaign ’19

Yes, I wish to participate in the 2019 Employee Giving Campaign.

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Telephone: ______________________________

Department: ______________________________

Email: ______________________________

Ways to Give

☐ **Pledge through an automatic payroll deduction (26 pay periods per year):**

- ☐ **60 Minute Club "Hour of Power":** Enroll me in the 60 Minute Club! My gift of one hour of pay per period will be automatically calculated & deducted.

  Or Consider: ☐ 30 min ☐ 90 min ☐ 120 min

- ☐ **Automatic Payroll Deduction:**
  - ☐ I gift $_______ per pay period.
  - ☐ I gift $_______ one time.

☐ **Paid Time Off (PTO) Donation:**
Note: An employee must have a minimum of 80 hours in their PTO account.
I gift ________ hours of accrued vacation time.

☐ **Cash/Check:** $____________ enclosed.

☐ **Credit card:** $____________ Please charge my:

☐ Visa ☐ MasterCard ☐ AmEx

☐ Monthly ☐ Quarterly ☐ One Time

____
Name as it appears on card

______________________________ __________
Credit Card Number Exp. Date:

Gift Designation

Please select from the following (maximum of two):

☐ **Beyond Health - Your New French Hospital**

☐ **Area of Greatest Need (Employee Giving Fund)**

☐ **Angel of Hope Fund at Hearst Cancer Resource Center**

☐ **Breast Cancer Prevention Fund**

☐ **Employee Assistance Fund***
**Donations to this fund are not tax-deductible*

If you select two funds, please choose between the following:

☐ Spilt my support equally between selected funds

☐ Spilt my support as follows:

Fund:________________Amount $__________

Fund:________________Amount $__________

Signature

All gifts to the French Hospital Medical Center Foundation are eligible for tax deduction to the fullest extent of the law except where noted. Gifts through payroll deduction are rolled over annually. You may modify, increase or cease your gift at any time by notifying the Foundation in writing.

I understand that, for whatever reason, should I cease to be an employee of French Hospital Medical Center, or should I no longer be able to fulfill my commitment due to personal circumstances, I am not obligated nor will I be held accountable to fulfill this commitment.

Signature (*required*): ______________________________

Employee # (*required*): ______________________________

Date: ______________________________

Return by mail, fax or drop off at the Gift Shop.

Thank you for your generosity!

French Hospital Medical Center Foundation
A Dignity Health Member

For questions, call 805.542.6496, fax 805.542.6264, or email Bianca.Melendez@DignityHealth.org