EMPLOYEE GIVING PROGRAM

At St. Michael's Hospital and Providence Healthcare we take on some of the world's toughest health challenges. We never say no. We never give up. Thanks to the generosity of our staff, we are able to bring health care to the next level. We thank you.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other ______________ ☐ Prefer not to say

First Name: ______________ Middle Initial: ____ Last Name: ______________

Home Address: ______________

City: ______________ Prov: ______________ Postal Code: ______________

Primary Phone: ______________ Work Phone: ______________

Preferred Email: ______________

Department: ______________ Employee ID # : ______________

Work Address: ______________

OPTION #1 – PAYROLL DEDUCTION

GIVING AMOUNT (per bi-weekly pay period)

☐ **$5 per pay** ($130 per year)

☐ **$10 per pay** ($260 per year)

☐ **$20 per pay** ($520 per year)

☐ **$40 per pay** ($1040 per year)

☐ **$50 per pay** ($1300 per year)

☐ **Other amount $** __________ ($5 minimum per pay)

By donating a minimum of $1000/year, you will become a member of our exclusive Leadership Society and receive special benefits.

☐ **Next pay period** ☐ **Effective date** ______________ ☐ **Other** ______________

☐ I hereby authorize a payroll deduction starting on the effective date listed above. I understand that this bi-weekly deduction will continue until revoked or changed in writing by me and that my donation will be reported as a charitable donation on my T4 each year.

Payroll deduction to St. Michael's Foundation is completely voluntary and can be cancelled at any time.
Your yearly tax-deductible donation amount will be recorded on your T4 for tax purposes.

OPTION #2 - MONTHLY GIVING PRE-AUTHORIZED PAYMENTS

Pre-Authorized Payments of ☐$15 ☐$30 ☐$50 ☐Other $ ______________ per month to be removed from my bank account or credit card. *Please attach a void cheque or provide your credit card info on the following page.*

OPTION #3 - ONE TIME GIFT

☐ One Time Gift of $ ____________

I WISH TO PAY BY:

☐ Payroll Deduction

☐ Cheque (payable to St. Michael's Hospital Foundation)

☐ Credit Card

☐ VISA ☐ MasterCard ☐ AMEX

Card No.: ____ ____ ____ ____ Exp.: __ / __ CVV: ____________

Name on Card: ____________

YOUR COMMITMENT WILL ALLOW THE FOUNDATION TO SUPPORT THE HOSPITAL'S MOST URGENT PRIORITIES, THANK YOU.

Signature: ____________

Email: ____________

Date: ____________

☐ I wish to remain anonymous.

☐ Preferred recognition name: ____________

☐ Yes, I would like to learn about getting involved with St. Michael's Foundation.

☐ I'd like to receive communications from St. Michael's Foundation.

☐ I'd like to receive my tax receipt by email. ____________

Tax receipt issued for gifts of $20 or more.

YOU CAN SUPPORT ST. MICHAEL'S HOSPITAL AND/OR PROVIDENCE HEALTHCARE WITH A PLANNED GIFT.

☐ I have included St. Michael's Foundation in my Will.

☐ I would like to receive a Personal Will Planner.

If you have questions, contact Julie Tsao at 416 864 6060 x46138 or **TsaoJ@smh.ca**

Please scan your completed form to **hello@stmichaelsfoundation.com**,
or through internal mail to St. Michael's Foundation, 2 Queen St E, 7th Floor, Suite 712.

Charitable Registration #122963663RR0001