



Employee Giving Program

When the stakes are high, when seconds count, when the unthinkable happens—gifts like yours show up. They show up in every piece of life-saving equipment. In every groundbreaking research breakthrough. In every effort to advance health equity and uplift our most marginalized community members. 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) | ☐ \$40 per pay (\$1040 per year) |
| ☐ \$10 per pay (\$260 per year) | ☐ \$50 per pay (\$1300 per year) |
| ☐ \$20 per pay (\$520 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 Hospital 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 Hospital Foundation.

☐ I'd like to receive communications from St. Michael's Hospital 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 with a planned gift.

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

☐ I would like to receive a Personal Will Planner.

If you have questions, contact us at 416 864 5000 or hello@stmichaelsfoundation.com

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

Charitable Registration #122963663RR0001