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: _____ 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

☐ **$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 $** _____ (per bi-weekly pay period)

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

☐ **Effective date** ☐ **Next pay period** ☐ **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.

PLEASE SCAN YOUR COMPLETED FORM TO:

info@stmichaelsfoundation.com

Or through internal mail to St. Michael's Foundation, 2 Queen St E, 7th Floor, Suite 712.

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 information below.*

OPTION #3 - ONE TIME GIFT

☐ One Time Gift of $ _____

Tax receipt issued for gifts of $20 or more. St. Michael's Hospital Foundation. Charitable Registration No. 12296 3663 RR0001

I WISH TO PAY BY:

☐ 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:

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 an e-receipt for my monthly or one-time donation.

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**