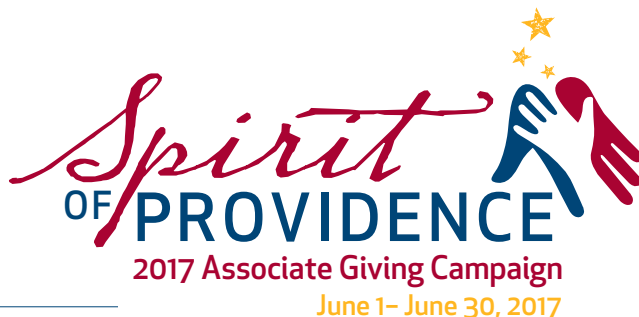


DONATION FORM

Associate Contact Information



NAME _____

DEPARTMENT _____

LOCATION _____

ASSOCIATE ID# (located on back of badge) _____

HOME STREET ADDRESS _____

CITY _____

STATE _____

ZIPCODE _____

EMAIL _____

Donation Information

Please accept my pledge of:

- \$5 per pay (\$130/year) \$10 per pay (\$260/year) \$20 per pay (\$520/year)
 \$38.46 per pay (\$1,000/year) \$57.69 per pay (\$1,500/year) \$76.92 per pay (\$2,500/year)
 Payroll Deduction *(The gift amount selected above will be deducted from each paycheck unless otherwise specified.)*

I would like to make my donation through the following form of payment *(Please check only one payment method.)*

- Cash
Amount Enclosed \$ _____
- Credit/Debit Card
Card Type: Visa Master Card American Express

CARD NUMBER _____

EXP. DATE _____

NAME ON CARD _____

SECURITY CODE _____

- Check *(Please make checks payable to: Providence Health Foundation)*
Amount Enclosed \$ _____

Gift Designation

Please designate my gift to *(please select only one fund):*

- Providence Health Fund *(Area of greatest need)* Nursing Education Initiative *(To support our nurses continued education and training)*
 Associate Bridge Fund *(Provides associate relief)* Patient Medication Assistance *(To assist in their discharge from the hospital)*
 Other Providence Health Facility *(Seton House, Carroll Manor, PFC, Ft. Lincoln, or Perry Family Health Center)*

Gift Recognition

- Please list my name as the following written below. Please make my gift anonymous.

ASSOCIATE SIGNATURE _____

DATE _____



All gifts are charitable donations and are tax deductible. Federal tax ID: 52-1275583.
Please return all forms and payments to the address below by June 30th. Attn: Karlie Blattner
1150 Varnum Street NE ★ Washington, DC 20017 ★ karlie.blattner@ascension.org ★ (202) 845-4280
providencehealthfoundation.org/spirit