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)*
- ☐ Associate Bridge Fund *(Provides associate relief)*
- ☐ Fort Lincoln
- ☐ Carroll Manor
- ☐ Patient Medication Assistance *(To assist in their discharge from the hospital)*
- ☐ 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: Christina Santos

1150 Varnum Street NE ★ Washington, DC 20017 ★ christina.santos@ascension.org ★ (202) 854-7978
providencehealthfoundation.org/spirit