



Colleague Giving Donation Form

Stmhfoundation@trinityhealthofne.org

or 203-709-6390

STEP 1: Colleague Information

Name: _____

Address: _____

Colleague ID #: _____

Phone: _____

Email: _____

Department: _____

STEP 2: Designation

- SMH Campus Beautification Initiative
- Colleague Crisis Fund
- Nursing Education
- Medical Residency Program
- Breast Screening Fund
- Area of Greatest Need

I want my gift to honor a colleague:

Name: _____ Department: _____

STEP 3: Contribution

Payroll Deduction

- Per paycheck (every two weeks):
 - \$20 \$10 \$4 \$2 Other: _____
- Onetime Deduction:
 - \$500 \$250 \$100 \$50 Other: _____

I understand deductions will rollover year to year unless I notify the Foundation at 203-709-6390 or complete a new donation form.

Cash or Check \$ _____
Payable to Saint Mary's Hospital Foundation

Credit Card: \$ _____
Credit Card #: _____
CVV Code: _____ Exp. Date: _____

Change my current deduction per paycheck (every two weeks) as of _____ (Date) to \$ _____

STEP 4: Appreciation Gift

Gifts of \$100 or more receive a hospital specific "be inspired" long-sleeve t-shirt: men ladies
 Small Medium Large X-Large 2XL 3XL no gift, thank you

STEP 5: Submit - Saint Mary's Hospital Foundation -stmhfoundation@trinityhealthofne.org

Signature (required): _____ Date: _____

- I am interested in including the hospital in my will or life insurance. Please contact me.
- I wish to remain anonymous on any publication of donors.