Colleague Giving Donation Form

foundation@trinityhealthofne.org or
860-714-4900

STEP 1: Colleague Information

Name:_____

Address:_____

_____

Colleague ID #: _____

Phone:_____

Email:_____

Department:_____

Paid by Livonia: ___Yes ___ No

STEP 2: Designation

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

STEP 3: Contribution

❑ **Payroll Deduction**

❑ **Per paycheck** (every two weeks):

☐ $20 ☐ $10 ☐ $4 ☐ $2 ☐ Other:_____

❑ **Onetime Payroll Deduction**:

☐ $500 ☐ $250 ☐ $100 ☐ $50 ☐Other:_____

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

❑ I understand deductions will rollover year to year unless I notify the Foundation at 860-714-4900.

❑ **Cash or Check $**_____

*Payable to **Saint Mary's Hospital Foundation***

❑ **Credit Card:** $ _____

Credit Card #:_____

Exp. Date: _____

STEP 4: Appreciation Gift

Gifts of $100 or more receive a hospital specific "be inspired" t-shirt: ☐ men ☐ ladies

☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2XL ☐ 3XL ☐ no gift, thank you

STEP 5: Submit - Saint Mary's Hospital Foundation - foundation@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.

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