

EMPLOYEE CHARITABLE DONATION FORM

DATE _____
 EMPLOYEE NAME: _____ EMPLOYEE #: _____
 DEPARTMENT: _____ EXT. #: _____
 NAME AS YOU WANT IT TO APPEAR ON ACKNOWLEDGEMENT: _____
 HOME MAILING ADDRESS: _____
 HOME PHONE: _____ E-MAIL: _____

CHARITABLE OPPORTUNITIES

1. <i>Yearly Gift</i>	Total	\$ _____
2. <i>Bricks</i> (\$100/brick; \$25/replica)(See order form on back)	Total	\$ _____
3. <i>Children's Miracle Network Radiothon/Telethon*</i>	Total	\$ _____
4. <i>Comstock Award Dinner</i> (\$100/ticket)	Total	\$ _____
5. <i>Kid for a Night</i> (\$175/ticket)*	Total	\$ _____
6. <i>Endowment</i>	Total	\$ _____
TOTAL PAYROLL DEDUCTIONS		\$ _____

*Proceeds benefit St. Luke's Children's Hospital

WHAT AREA WOULD YOU LIKE TO SUPPORT?

- | | |
|--|--|
| <input type="radio"/> Children's Hospital | <input type="radio"/> Patient Assistance |
| <input type="radio"/> Emergency Services | <input type="radio"/> Nursing Excellence |
| <input type="radio"/> Center for Heart & Vascular Health | <input type="radio"/> Surgical Services |
| <input type="radio"/> Hospice | <input type="radio"/> Women's Services |
| <input type="radio"/> MSTI | <input type="radio"/> Other _____ |

HOW WOULD YOU LIKE TO PAY?

(Choose either A. Payroll Deduction, B. Credit Card, or C. Personal Check below)

A. Payroll Deduction

hours per pay period: _____ (1 hour/pay period minimum). Will be continued until you notify Foundation Office
 Regular Hours or PTO Hours

OR

Dollars per pay period: \$ _____ (\$10/pay period minimum). Will be continued until you notify Foundation Office.

Start Date: _____ Signature: _____

B. Credit Card

Please bill my: Visa MasterCard American Express Discover

Account # _____ Exp. Date: ____/____ Signature _____

C. Personal Check

PLEASE MAKE CHECK PAYABLE TO ST. LUKE'S HEALTH FOUNDATION.

Please return this document to the Foundation Office by interoffice mail or by fax.

If you have any questions, please contact St. Luke's Health Foundation. Phone: 381-2123 Fax: 381-4673

Thank you very much for your gift.

You will receive an annual summary receipt for IRS purposes after the last pay period in December.

Engraved Brick Purchase

EMPLOYEE NAME: _____ **EMPLOYEE #:** _____

DEPARTMENT: _____ **EXT. #:** _____

HOME MAILING ADDRESS: _____

HOME PHONE: _____ **E-MAIL:** _____

Inscription Guidelines:

- 16 characters per line, including spaces and punctuation marks. You may use any symbol on a standard computer keyboard.
 - Inscriptions will communicate non-commercial messages only. Company names can be used. Phone numbers, e-mail and web addresses, slogans, sales pitches, and logos cannot be used. **We cannot guarantee location of your brick.**
 - Please print using one letter, symbol, or space per box.
 - St. Luke's reserves the right to approve all text prior to production. You will receive a confirmation letter in 2-3 weeks to review the imprint as it will appear on your brick.
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Number of Bricks:

Engraved Brick(s) _____ X \$100 each = \$ _____

Replica Brick(s) _____ X \$25 each = \$ _____ (Replica offered at reduced price for St. Luke's staff only.)

Replica brick(s) ships in 6-8 weeks.

GRAND TOTAL \$ _____

Ship Replica To:

Name: _____

Address (*Cannot ship to PO Box*): _____

City/State/Zip: _____

Daytime Phone: _____ E-mail: _____

My Brick Should be Inscribed as Follows:

Line 1:

T T T T T T T T T T T T T T T T

Line 2:

T T T T T T T T T T T T T T T T

Line 3:

T T T T T T T T T T T T T T T T

**We are unable to accommodate requests for refunds; thank you for your understanding.*

Please send your order form to the Health Foundation office by interoffice mail or fax it to 381-4673.

Thank you very much for your gift!