McCullough-Hyde
MEMORIAL HOSPITAL TRUST
Giving is Good Medicine

Team Member Giving Form

Thank you for your support of the McCullough Hyde Memorial Hospital Trust.

McCULLOUGH-HYDE MEMORIAL HOSPITAL TRUST

Employee Name: _____ Emp. No. _____ Dept. _____
Address: _____
City, State, Zip: _____
Phone H: _____ W:_____ C:_____
Email: _____

____I pledge to make a gift through the **payroll deduction program** to the McCullough-Hyde Memorial Hospital Trust

( ) **Pledge**: (all deductions to start with the first pay period in _____)

I authorize my employer to deduct:

( ) A **one-time deduction** of $ _____

( ) $ _____ **per pay** for _____ **pay period/s** for a total pledge of $ _____

( ) Other (specify) _____

Employee Signature: _____ Date: _____

( ) My gift is _____ a memorial _____ an honor gift for _____

( ) My gift is for the *Campaign for the Emergency Department and Surgery Suite*

( ) My gift is for _____

Other Payment Options (if you are not participating in payroll deduction)

___Check; payable to McCullough-Hyde Memorial Hospital Trust

___Credit card # _____ Exp. date _____

Employee Signature: _____ Date: _____