



# Sunnyview

Rehabilitation Hospital Foundation

## 2009 Employee Giving Campaign

*Supporting*

### The Patient Needs Scholarship Fund

***Your participation is what makes the difference!***

Name (Please Print): \_\_\_\_\_

Extension:    x \_\_\_\_\_                      Department: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home/Cell phone: (518) \_\_\_\_\_ - \_\_\_\_\_

[ ] 1<sup>st</sup> Shift    [ ] 2<sup>nd</sup> Shift            [ ] 3<sup>rd</sup> Shift    Other: \_\_\_\_\_

**Option 1: Payroll deduction:**

I authorize the following deduction from my bi-weekly paycheck:

- [ ] **\$2**    x 26 pay periods = **\$52** total annual gift
- [ ] **\$3**    (\$78)
- [ ] **\$5**    (\$130)
- [ ] **\$10** (\$260)
- [ ] **\$15** (\$390)
- [ ] **\$20** (\$520)
- [ ] **\$50** (\$1,300)
- [ ] \_\_\_\_\_ Other Amount

My gift is for ...

- [ ] Patient Needs Scholarship Fund
- [ ] Unrestricted Support
- [ ] Specific Department/Program: \_\_\_\_\_

*\*Please be sure to sign this form below\**

**Payroll Perpetual Giving Option:**

[ ] For as long as I work at Sunnyview, I would like my above noted gift taken out of my paycheck every pay period, unless I authorize otherwise.

**Option 2: Cash/Check Donation:**

[ ] I would prefer to make a one time cash donation of \$ \_\_\_\_\_.

**Option 3: Credit/Debit Card Donation:**

Please charge my:    [ ] Visa            [ ] MasterCard

in the amount of \$ \_\_\_\_\_            [ ] Once Only        [ ] Monthly

Credit Card Number: \_\_\_\_\_            Expiration: \_\_\_\_\_

**\*Signature Required\***

*Thank you!*