capitalhealth

EMPLOYEE GIVING PROGRAM

PAYROLL DEDUCTION FORM

PLEASE RETURN THIS FORM TO THE DEVELOPMENT OFFICE NOT TO PAYROLL

PAYROLL DEDUCTION & GIFT INFORMATION

I hereby authorize my employer, Capital Health, to deduct from my paycheck the amount listed below. I understand that I may withdraw from this plan at any time by making a written request to the Development Office.

- ❑ $25 per pay
- ❑ $20 per pay
- ❑ $10 per pay
- ❑ $5 per pay
- ❑ $2 per pay
- ❑ Other $ _____

❑ Continue this deduction indefinitely. ❑ Please end on _____

Direct my gift:

- ❑ Where the need is greatest
- ❑ Employee Catastrophic Relief Fund
- ❑ Registered Nurse Education Fund
- ❑ Other_____

❑ I wish to remain anonymous.

EMPLOYEE INFORMATION

First Name MI Last Name Employee ID

Department Work Phone

Home Address City State Zip

Home Phone

Signature_____ *(Required)* Date_____ *(Required)*

We appreciate your consideration of this appeal. If you wish to be removed from future fundraising appeals, please call 609.303.4121, send a written request with your name and address to Capital Health Development Office, Two Capital Way, Suite 361, Pennington, NJ 08534, or e-mail your request to donate@capitalhealth.org. A copy of our registration and financial information may be obtained from the Office of the Attorney General of the State of New Jersey by calling 973.504.6215. Registration does not imply endorsement.