



**CCH PAYROLL DEDUCTION FORM – LICENCE # M741018**

**Personal Information:**

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Full Mailing Address: \_\_\_\_\_ Unit: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employee # \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (office): \_\_\_\_\_ Ext: \_\_\_\_\_

Department \_\_\_\_\_  18 years of age or older

**Payroll Deduction:**

Minimum Purchase of 4 tickets @ \$3.00 = **\$12.00** to be deducted from each pay

If you would like to purchase more than 4 tickets: \_\_\_\_\_ tickets @ \$3.00 = \$ \_\_\_\_\_ to be deducted from each pay

I authorize the Cornwall Community Hospital Foundation (CCHF) to deduct \$ \_\_\_\_\_ from each pay bi-weekly inclusively until I cancel it. You must give the Foundation office at least 10 days notice prior to cancelling. If your employment with CCH should cease, your contributions will cease as well and your tickets will be removed from the draw. If you wish to continue, please see the Foundation office to make payment arrangements.

I have read the rules and accept the terms and conditions

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please email, fax, mail or drop off this form to:**

Cornwall Community Hospital Foundation  
840 McConnell Ave.  
Cornwall, ON K6H 5S5  
Fax: (613) 930-4509 Phone: (613) 930-4508  
Email: [rhonda.simpson@cornwallhospital.ca](mailto:rhonda.simpson@cornwallhospital.ca)

***To be completed by Foundation Staff:***

*Ticket Numbers:* \_\_\_\_\_

*First Draw Date:* \_\_\_\_\_