DRH
HEALTH FOUNDATION

FOUNDATION MEMBERSHIP

PAYROLL DEDUCTION AUTHORIZATION FORM

I, _____ (please print) authorize Duncan Regional Hospital, my employer, to deduct $_____ per pay period beginning with the first pay period of next month and totaling $_____.

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Please apply my contribution to the following (to equal 100%):

____ Hands on Health Interactive Center _____ Nursing Scholarships

____ Hospital Medical Equipment _____ Chisholm Trail Hospice

____ Taylor Le Norman/McCasland Cancer Center

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By my signature below, I acknowledge that I have read and understand the above and I agree to the terms therein.

_____ _____ _____

Team Member Signature Team Member # Date

To make a gift is simple and the amount is totally up to you. Most importantly, please remember that no matter the size of your gift, your generosity will benefit the lives of others