Baptist Memorial Health Care Foundation
Payroll Deduction Donation Authorization Form

Employee Name: _____ SSN#: _____-_____-_____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Entity: _____

Pledge:

	New Pledge	Amount (per pay period)	$
	Change current Pledge	New Amount (per pay period)	$
	One-Time Donation	Amount	$
	STOP my current deduction		

I would like my gift to support the area(s) listed below.

- □ Making a difference where the need is greatest
- □ Patient Assistance Fund
- □ Employee Emergency Assistance Fund
- □ Spence and Becky Wilson Baptist Children's Hospital
- □ Baptist College of Health Sciences General Fund
- □ Baptist Cancer Center
- □ Baptist Heart Institute
- □ Chaplain's Fund
- □ Baptist Trinity Hospice
- □ Baptist Reynolds Hospice House
- □ Priceless Wishes for Hospice Patients
- □ Matthew Hindman Fund (patient assistance for children and adolescents
- □ Neonatal Intensive Care Unit (NICU)
- □ Center for Good Grief
- □ Baptist Memory Care Center
- □ Baptist Memorial Hospital - _____
- □ Other (please specify one or more): _____

I authorize my employer to deduct this amount from each paycheck. I understand this authorization will continue unless otherwise specified by me in writing. I understand all personal information will be kept confidential. The Baptist Memorial Health Care Foundation does not provide goods or services as whole or partial consideration for any contribution.

Employee Signature: _____ Date: _____

Thank you for your pledge. Your contribution really does make a difference!

Baptist Memorial Health Care Foundation
(901) 227-7123 phone (901) 227-6190 fax
www.bmhgiving.org