Swedish Hospital Foundation

Employee Contribution Form

Name: ______________________________

Department: ______________________________

Home Address: ______________________________

____

Home Phone: ______________ Work Ext.:__________

Employee ID#: ______________ Cost Center: __________

Yes, I would like to make a donation to:

___ Employee Benevolence
___ COVID19 Relief
___ Dentistry
___ Women's Health
___ Cancer Survivorship
___ Nursing
___ Helping Hands
___ Galter LifeCenter
___ Greatest Need
___ Other ____________________

___ **Check**: I have enclosed my check in the amount of $__________ made payable to Swedish Hospital Foundation.

___ **Credit Card**: Please charge the following credit card in the amount of $________

Credit Card #: ____ Expiration Date: ______

___ **Payroll Deduction**: I would like to make a gift of $_________ via payroll deduction.

___ Please deduct $_______ as a one-time donation.

___ Please deduct $_______ per pay period until this donation amount is realized.

___ Please deduct $_______ indefinitely.

NOTE: Deductions may begin as soon as the first pay period after your pledge unless you select an alternate start date.

Total Gift Amount	Amount per pay period*
$1,000	$ 38.46
$ 500	$ 19.23
$ 250	$ 9.62
$ 100	$ 3.84
$ 50	$ 1.92

*One-year pledge

___ **PTO Donation**: I would like to donate _____ hours of PTO at 100% (after taxes).

I would like to be recognized as ____

___ I wish for my gift to be anonymous.

Signature: ____ Date: ______________________

Please email this form to **Foundation@SwedishCovenant.org** or mail to: Swedish Hospital Foundation, 5145 N. California Avenue, Chicago, IL 60625