EMPLOYEES LEND A HAND: Mercy Hospital of Folsom Blankets for Patients

GETTING STARTED IS EASY

Simply complete the information below and send to Mercy Foundation through interoffice mail. If completing electronically, download this form first so it can be saved with your information. You may also email your form to mercyfoundationsac@ dignityhealth.org or fax your form to (916) 851-2724.

Yes! I would like to donate now to help add blankets to the supplies on our comfort carts.

EMPLOYEE ID (required)	First Name	Last Name
Home address	City	State Zip
Phone	E-mail (By providi	ling your e-mail, you are opting in to receive electronic communications from Mercy Foundation)
Signature (type full name)	Date (r	mm/dd/yyyy)
Work facility: 🛛 MHF 🗖 OTHER	Employee	e of: Dignity Health Dignity Health Medical Foundation
Print your name as you would like it to appe	ear in donor recognitior	n: I would like to remain anonymous
PAYROLL GIVING OPTIONS		
Payroll Deduction Please deduct \$		🗖 per pay period (26 pay periods per year) 🗖 One-time
PTO Donation Please deduct ho	urs 🛯 per pay period (26	<i>6 pay periods per year)</i>
IMPORTANT PTO DONATION INFORMAT	ION	
 Donations can be made in one-hour increment A minimum of 80 hours of accrued PTO is re- 	nts and are converted to o quired at the time of your ayroll taxes and will be rep	r donation ported as wages on your W-2 form in the calendar year in which the
OTHER GIVING OPTIONS		
Check Enclosed in the amount of \$		(make check payable to Mercy Foundation)
Credit Card Please charge \$		to my 🗖 VISA 🗖 MasterCard 🗖 AMEX
I would like my card to be charged Done-time	ie 🗖 Monthly 🗖 Bi-m	ionthly 🗖 Quarterly

Card #

Exp. Date

Thank you for lending a hand!

Visit **www.supportmercyfoundation.org** or call Mercy Foundation at (916) 851-2700 for more information.

