# Employee Giving

Dignity Health Foundation®
Inland Empire

As a Dignity Health employee we cannot thank you enough for the quality care you provide our patients and our community. Today, you have the opportunity to go above and beyond your everyday work to make a bigger impact on the patients we serve through the generosity of a financial contribution to the **Employee Giving Campaign**. Your financial support of our facilities helps us advance our mission and ultimately improve the lives of our patients and their families. Please consider joining your fellow employees by selecting one of the gift / pledge options detailed in this brochure. Your donation can be restricted to the hospital and even the department/ fund of your choice. Your gift will help to sustain our ability to provide patients with high quality care and state-of-the-art medical equipment and technology

EMPLOYEE NAME

EMPLOYEE ID NUMBER

## YES! I want to support our healing ministry!

**Please accept my gift of:**

❑ $250 ❑ $1,000 Other $ _____

❑ **Automatic Payroll Deduction**
per pay period to be automatically deducted from my paycheck.

$10 per pay period = $250 annual gift

$38.47 per pay period = $1,000 annual gift

❑ **PTO Donation**
I request to make the following PTO donation election to the Foundation. I understand that in order to donate the PTO hours elected, I must have a minimum of 80 hours in my account at the time I make this election. If there are insufficient funds, no donation will occur. PTO donations are subject to all applicable payroll taxes and will be reported as wages on my IRS W-2 form in the calendar year in which the PTO hours are donated. Donations must be made in whole hour increments that are converted to cash.

A one-time donation of _____ PTO hour(s).

SIGNATURE

DATE

❑ **Enclosed is my check made payable to:**
Dignity Health Foundation Inland Empire

**Please charge my** ❑ Visa ❑ MasterCard
❑ American Express ❑ Discover

CARD NUMBER EXP. DATE

BILLING ZIP CODE CODE (3-4 DIGIT)

SIGNATURE

PHONE NUMBER

❑ **Please designate my gift to:**
❑ Community Hospital of San Bernardino

❑ St. Bernadine Medical Center

❑ **Please further designate my gift to:**
❑ Area of greatest need (Medical Equipment fund)

❑ Employee Assistance fund

❑ Women of Dignity Health

❑ Other (ex. Department, Mission Services, etc.)

Please enclose payment and mail this form to:
**Dignity Health Foundation - Inland Empire**
PO Box 2637, San Bernardino, CA 92406

No goods or services are provided in exchange for this contribution. Your contribution is tax deductible to the extent of the law. Consult your tax advisor for more information.