

Stillwater Medical

FOUNDATION

Employee Payroll Deduction Donation

Name _____ Badge # _____
Mailing Address _____
City _____ State _____ ZIP _____
Phone _____

AUTHORIZATION

I authorize a deduction of \$ _____ per pay period from my payroll account.

This deduction will continue until I notify the Stillwater Medical Foundation of my desire to change or discontinue. (Deductions will begin the next available pay period after submission.)

I authorize a ONE TIME GIFT by payroll deduction of \$ _____.

DIRECTIVE

My donation is designated for:

If "other" please specify: _____

My donation is in _____ of: _____

Signature

Date

Once you have completed this form, save it to your computer. Send the saved file by email to Jessica Krok, jkrok@stillwater-medical.org or print and fax it to 405-742-5768.