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:

Unrestricted

If "other" please specify: _____

☐ My donation is in memory of: _____

_____ _____

Signature **Date**

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