

Broward Health Employee Giving Campaign

Name _____ Home Address _____
 Employee Number _____ City, State Zip _____
 Facility _____ Department Name and # _____
 Preferred Email Address: _____ Phone: _____

Tell us how you want to give

A. Payroll Deduction

Select your payroll deduction amount

- \$2 per payroll / \$52 per year
- \$5 per payroll / \$130 per year
- \$10 per payroll / \$260 per year
- \$20 per payroll / \$520 per year - Qualifies for Young President's Council membership if 45 years old or younger
- \$25 per payroll / \$650 per year
- \$40 per payroll / \$1,040 per year - Qualifies for President's Council membership
- \$50 per payroll / \$1,300 per year
- Other: \$____per payroll X 26 = \$____per year

B. Personal Leave (PL) Deduction

- I authorize a one-time net donation of \$_____ utilizing my PL hours.
- I authorize a one-time deduction of _____ PL hours.

Note: Your donation is net of taxes (PL hours times hourly rate; less appropriate taxes)

C. One-Time Donation Option

- Check (payable to Broward Health Foundation)
- Cash -- \$_____
- Credit Card – credit card donations may be made online at browardhealthfoundation.org/empgiving

Tell us how you want your gift directed

Your gift will directly benefit the facility where you work. If you want to direct your gift to a different facility, please indicate your selection below.

- | | |
|---|---|
| <input type="checkbox"/> Broward Health Foundation | <input type="checkbox"/> Broward Health Weston |
| <input type="checkbox"/> Broward Health Medical Center | <input type="checkbox"/> Broward Health Community Health Services |
| <input type="checkbox"/> Salah Foundation Children's Hospital | <input type="checkbox"/> Gold Coast/Hospice |
| <input type="checkbox"/> Broward Health Coral Springs | <input type="checkbox"/> Gold Coast/Home Health |
| <input type="checkbox"/> Broward Health Imperial Point | <input type="checkbox"/> Children's Diagnostic & Treatment Center |
| <input type="checkbox"/> Broward Health North | |

Please Sign and Date

Signature –required (your signature authorizes your commitment) _____ Date _____

- Check here if you DO NOT want your name listed on any printed materials in recognition of your gift.

Return this form to your HR Department