

iGive

CIRCLE OF FRIENDS EMPLOYEE GIVING CAMPAIGN

Yes, I wish to participate in Circle of Friends.

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____

Department: _____

E-mail: _____

Ways to Give

**Pledge through an automatic payroll deduction
(26 pay periods per year):**

Healing Hour Club: Enroll me in the Healing Hour Club! My gift of one hour of pay per pay period will be automatically calculated and deducted from each paycheck.

Automatic Payroll Deduction:

I gift \$ _____ per pay period.

I gift \$ _____ one-time deduction.

Paid Time Off (PTO) Donation:

I gift _____ hours of accrued vacation time.

Note: An employee must have a minimum of 80 hours in their PTO account to make this election.

Cash/Check Donation: \$ _____ enclosed.

Credit Card Donation: \$ _____

Please charge my Visa MasterCard

Annually Semi-annually Quarterly One Time

Name as it appears on card:

Credit Card Number:

Exp. Date _____

 **Marian Regional
Medical Center Foundation.**
A Dignity Health Member

November 1-30, 2018

Gift Designation

Please select from the following (maximum of two):

- Where the need is greatest
- Emergency Services
- Pediatrics
- Family Medicine Residency Program
- OB/GYN Residency Program
- Friendship Fund (*employee assistance*)
non-deductible contribution
- Patient Assistance Program
- Mission Hope Cancer Center for Marian Cancer Care
- Sue J. Sword Heart Center
- Maternal and Newborn Care
- Newborn Intensive Care Unit
- Home Health and Hospice
- Marian Extended Care Center
- Spiritual Care
- Pacific Central Coast Health Centers
formerly Marian Community Clinics

If you select two funds, please choose between the following:

- Split my support equally between the selected funds
- Split my support as written next to each selected fund

Signature

All gifts to the Marian Foundation are completely tax deductible, except where noted. Gifts by payroll deduction are rolled over annually. You may modify, increase, or cease your gift at any time. I understand that if I cease to be an employee of Marian, or am unable to fulfill my pledge, I am neither obligated nor will I be held accountable to fulfill this pledge.

Signature (required): _____

Employee # (required): _____ Date: _____

**For questions, call 805.739.3595, fax 805.739.3599,
or e-mail MarianFoundationFeedback@DignityHealth.org
supportmarianmedical.org/CircleofFriends**

Thank you for your support!

**Give
Hope**



**Give
Love**



**Give
Life**

