SHN FOUNDATION

SHN EMPLOYEE DONATION FORM

For more information, please contact Lisa Marinis, Campaign Officer, SHN Foundation
Email: lmarinis@shn.ca | Telephone: 416-438-2911 ext. 7615

YES! I would like to support Scarborough Health Network and the patients I serve each day by making a gift today.

INFORMATION

(PLEASE PRINT) **ALL FIELDS MUST BE COMPLETED IN THIS SECTION**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Employee ID #: _____

First Name: _____ Last Name: _____

SHN Department: _____ Hospital: ☐ Birchmount ☐ Centenary ☐ General

Home Address: _____ Suite or Apt #: _____

City: _____ Province: _____ Postal Code: _____

Home #: _____ Cell #: _____

Work #: _____ Email: _____

RECOGNITION FOR *IT'S OUR TIME* CAMPAIGN DONORS

Gifts and pledges of $5,000 or more will be listed on the Foundation Donor Wall at three hospitals.

Recognition Name: _____
(This name will be listed on the Donor Wall)

NOTE: Gifts and pledges of $50,000 or more will receive an opportunity to dedicate an area within the hospital.

MY GIFT IS IN SUPPORT OF:

- ☐ New Bridletowne Neighbourhood Centre
- ☐ New Emergency - Centenary hospital
- ☐ New Emergency - Birchmount hospital
- ☐ New Medical Imaging and Vascular Centre - General hospital
- ☐ Campaign Greatest Need
- ☐ OTHER: _____

PLEASE CHOOSE ONE OF THE FOLLOWING PAYMENT TYPE OPTIONS FOR YOUR GIFT.

OPTION 1: PAYROLL PAYMENT

☐ **A)** Deduct $ _____ bi-weekly through payroll starting on (pay date): _____

☐ **B)** I would like to make a pledge of $ _____ over _____ years to be deducted from my payroll bi-weekly

Payroll deductions are recorded on your T4 for income tax reporting.

OPTION 2: PERSONAL PAYMENT

☐ **A)** I would like to make a pledge of $ _____ over _____ years. **Payment Schedule:** ☐ Monthly ☐ Annually

☐ **B)** I would like to make a one-time gift of $ _____

METHOD OF PAYMENT:

- ☐ Cash
- ☐ Visa
- ☐ MasterCard
- ☐ American Express
- ☐ Cheque **(PAYABLE TO SHN FOUNDATION)**
- ☐ Post-Dated Cheque *(mail to address below)*

Credit Card Information:

Card #: _____

Expiry Date: _____

Cardholder's Name: _____

Cash gifts will be receipted by the Foundation for donations of $10 or more.

HONOURING A CO-WORKER:

Name: _____ Department: _____ Hospital: _____

THANK YOU!

Scarborough Health Network Foundation
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