

# The Standard of Excellence in Health Care



SADDLEBACK  
MEMORIAL  
FOUNDATION

NAME \_\_\_\_\_ DEPARTMENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ SHIFT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## WAYS TO GIVE:

*All gifts to the Saddleback Memorial Foundation are eligible for tax deduction to the fullest extent of the law.*



### HOOR CLUB:

Enroll me in the "Hour Club" through Automatic Payroll Deduction. My gift of an hour of pay per pay period will be automatically calculated for me.



### AUTOMATIC PAYROLL DEDUCTION:

Deduct \$ \_\_\_\_\_ per pay period from my paycheck.



### PTO HOURS:

Deduct \_\_\_\_\_ PTO Hours per pay period (1 Hour Per Pay Period Minimum) through an Automatic Payroll Deduction. (Note: Donating PTO will be reflected as income on your payroll check and your tax-deductible amount will be figured AFTER-TAX. For your convenience, the Foundation will send you a letter stating your charitable contribution.)



### INSTALLMENT PLAN:

Initial payment of \$ \_\_\_\_\_ enclosed.

Please bill me: \$ \_\_\_\_\_ annually \$ \_\_\_\_\_ semi annually \$ \_\_\_\_\_ quarterly



**CREDIT CARD PAYMENT:** Please charge my:  VISA  MASTERCARD  AMEX

Annually \$ \_\_\_\_\_ Name as on card: \_\_\_\_\_

Semi-Annually \$ \_\_\_\_\_ Credit Card Number: \_\_\_\_\_

Quarterly \$ \_\_\_\_\_ Expiration Date: \_\_\_\_\_



### CASH/CHECK PAYMENT:

A cash/check gift of \$ \_\_\_\_\_ is enclosed.



I would like to make my pledge continuous until I request otherwise.

— or —



I would like my pledge to be valid during the calendar year, starting with the first automatic payroll deduction or installment check received by Saddleback Memorial Foundation, and having it end with the last pay period of the calendar year, unless I specify special instructions below.

I understand should any financial difficulty arise, I may amend or cancel this pledge at any time.



I do not wish to participate in the Employee "I Care" Annual Giving Fund.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

*If you have any questions regarding your pledge, please call  
Saddleback Memorial Foundation at (949) 452-3724.*

In support of providing the "Standard of Excellence in Health Care" at Saddleback Memorial Medical Center, I wish to make the following gift/pledge to Saddleback Memorial Foundation through the Employee "I Care" Annual Giving Fund.