Employee Giving Form

Please return form to:
Eskenazi Health Foundation
Fifth Third Bank Building, 5th Floor
720 Eskenazi Avenue
Indianapolis, IN 46202

317.880.4900
317.880.0505 (Fax)
EskenaziHealthFoundation.org

Name (please print): _____ Employee #: _____

Department: _____ Building: _____ Floor: _____

Home Address: _____
street city state zip

Phone: _____ _____ _____
home cell work

Preferred Email: _____

Program Designation (if left blank, unrestricted):_____

Payment method: Payroll deduction, credit card, check

Payroll Deduction: I hereby authorize Eskenazi Health or Health & Hospital Corporation to deduct and withhold the amount specified below from each of my payroll checks as a donation to Eskenazi Health Foundation. I understand that I may revoke Payroll Deduction at any time upon written notice to Eskenazi Health Foundation. ***Payroll deduction requires a minimum total gift of $50 with a minimum of $10 per pay period.***

I would like to: Enroll in Payroll Deduction (Change my current gift amount

My total gift is $ _____. I would like to give $ _____ per pay period beginning _____

Per Paycheck	$10	$15	$20	$25	$30	$40	$50	$77	$100
Total Per Year	$260	$390	$520	$650	$780	$1,040	$1,300	$2,002	$2,600

☐ **Credit Card**

I would like to make a:
☐ one-time gift of $_____.
☐ recurring gift of $_____ per ☐ month/☐ year (please pick one)

Type of Card: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Card Number: _____ Expiration: _____ CIV: _____

☐ **Check** (enclosed and payable to Eskenazi Health Foundation)

Check number: _____ Amount: $_____

Employee Signature: _____ *Date:* _____

Foundation Signature: _____ *Date:* _____

Thank you for supporting Eskenazi Health and its mission to advocate, care, teach and serve!