



FOUNDATION

PULLMAN REGIONAL HOSPITAL

ANNUAL GIVING FOR EXCELLENCE FUND DRIVE

EMPLOYEE PAYROLL DEDUCTION FORM

Name _____

Address _____

City, State, Zip _____

Phone: (Work) _____ (Home) _____ Email: _____

I would like to donate the following amount per pay period until further notice:

\$ _____ (minimum \$5.00)

I would like to make a one-time gift in the amount of \$ _____

- Attached is my check
- Please charge my credit card

Card Number _____ Expiration Date: _____

Please direct my pledge/gift to support:

- Annual Fund Drive – Pullman Regional Hospital Highest Needs

How would you like your name listed in donor recognition materials?

(Please Print) _____

Signature _____ **Date** _____

Please fax or return this form to:

PRH Foundation

840 SE Bishop Blvd., Suite 200, Pullman, WA 99163

Office (509) 332-2046 Fax (509) 332-2111

Internal Use Only

Foundation Staff: _____ Date: _____

HR Staff: _____ Date: _____

Deduction Start Date: _____

Per Pay Period Deduction Amount: _____ Annual Deduction Amount \$ _____

***Gifts are tax deductible to the extent provided by law.
All donations are confidential.***