PROVIDENCE
HEALTHCARE FOUNDATION

Employee Giving Program

At Providence Healthcare, we believe that personalized care matters. That patients should never be defined by their age, injury or illness. That every individual deserves dignity and the opportunity to thrive.
Thank you for making that possible.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____ ☐ Prefer not to say

First Name: _____ Middle Initial: ____ Last Name: _____

Home Address: _____

City: _____ Prov: _____ Postal Code: _____

Primary Phone: _____ Work Phone: _____

Preferred Email: _____

Department: _____ Employee ID # : _____

Work Address: _____

Option #1 – Payroll Deduction

Giving Amount (per bi-weekly pay period)

☐ $5 per pay ($130 per year)
☐ $10 per pay ($260 per year)
☐ $20 per pay ($520 per year)
☐ $40 per pay ($1040 per year)
☐ $50 per pay ($1300 per year)
☐ Other amount $ _____ ($5 minimum per pay)

By donating a minimum of $1000/year, you will become a member of our exclusive Leadership Society and receive special benefits.

☐ Next pay period ☐ Effective date _____ ☐ Other _____

☐ I hereby authorize a payroll deduction starting on the effective date listed above. I understand that this bi-weekly deduction will continue until revoked or changed in writing by me and that my donation will be reported as a charitable donation on my T4 each year.

Payroll deduction to Providence Healthcare Foundation is completely voluntary and can be cancelled at any time.
Your yearly tax-deductible donation amount will be recorded on your T4 for tax purposes.

Option #2 – Monthly Giving Pre-authorized Payments

Pre-Authorized Payments of ☐ $15 ☐ $30 ☐ $50 ☐ Other $ _____ per month to be removed from my bank account or credit card. *Please attach a void cheque or provide your credit card info on the following page.*

Option #3 – One Time Gift

☐ One Time Gift of $ _____

I Wish To Pay By:

☐ Payroll Deduction

☐ Cheque (payable to Providence Healthcare Foundation)

☐ Credit Card

☐ VISA ☐ MasterCard ☐ AMEX

Card No.: | | | | | | | | | | | | | | | | Exp.: | | / | | CVV: _____

Name on Card: _____

Your Commitment Will Allow the Foundation to Support the Hospital's Most Urgent Priorities, Thank You.

Signature: _____

Email: _____

Date: _____

☐ I wish to remain anonymous.

☐ Preferred recognition name: _____

☐ Yes, I would like to learn about getting involved with Providence Healthcare Foundation.

☐ I'd like to receive communications from Providence Healthcare Foundation.

☐ I'd like to receive my tax receipt by email. _____

Tax receipt issued for gifts of $20 or more.

You Can Support Providence Healthcare Hospital With a Planned Gift.

☐ I have included Providence Healthcare Foundation in my Will.

☐ I would like to receive a Personal Will Planner.

If you have questions, contact Alana Fiander at 416 285 3800 or **hello@phcf.ca**

Please scan your completed form to **hello@phcf.ca**, or through internal mail to
Providence Healthcare Foundation, 3276 St. Clair Avenue East, Scarborough, M1L 1W1.

Charitable Registration #122963663RR0001