Swedish Covenant Hospital
Foundation

Employee Contribution Form

Yes, I wish to make a contribution to Swedish Covenant Hospital.

Name: _____
Department: _____
Home Address: _____
_____
Home Phone: _____ Work Ext.:_____
Employee ID#: _____ Cost Center: _____

Please select your method of payment:

☐ **Check**: I have enclosed my check in the amount of $_____ made payable to the Swedish Covenant Hospital Foundation.

☐ **Credit Card**: Please charge the following credit card in the amount of $_____
_☐_ VISA _☐_ MasterCard _☐_ Discover _☐_ American Express

Credit Card #: _____Expiration Date: _____

☐ **Payroll Deduction**: I choose to make my gift of $_____ via payroll deduction. Please deduct $_____ per pay period until this donation amount is realized.

Gift Amount	Amount per pay period (One-year pledge)
$3,000	$192.31
$1,000	$ 38.46
$500	$ 19.23
$250	$ 9.62
$100	$ 3.84
$50	$ 1.92

NOTE: Deductions may begin as soon as the first pay period after your pledge unless you select an alternate start date.

☐ **PTO Donation**: I would like to donate _____ hours of PTO at 100% (after taxes).

Please select the specific fund your gift will support:
_☐_ Unrestricted _☐_ Women's Health _☐_ Cancer _☐_Other _____

Please indicate how you wish to be listed on any recognition.

_____ ☐I wish for my gift to be anonymous.

All gifts are tax-deductible to the extent provided by law.

Signature: _____ Date: _____

Thank You! Your gift, in any amount, is greatly appreciated.
Please email to: foundation@schosp.org, or mail to:
Swedish Covenant Hospital Foundation, 5145 N. California Avenue, Chicago, IL 60625
For more information, please call 773-293-5121.