



Whenever possible, please submit Payroll Deduction Authorizations online at:

<https://www.osfhealthcarefoundation.org/missionpartnergiving>

Please do **not** submit a paper form if an online form has been submitted.

Employee Authorization for Payroll Deduction

Name: _____

Work Phone: _____ Employee ID #: _____

Home Address: _____

City, Zip: _____ Department: _____

I would like to donate the following to OSF HealthCare Foundation:

\$ _____ Each Pay Period OR \$ _____ as a One-Time Payroll Deduction

Please limit your selection to one fund.

Location Funds – Mission Partner Area of Greatest Need:

- | | | |
|---|---|---|
| <input type="checkbox"/> SAHC Alton | <input type="checkbox"/> SMMC Galesburg | <input type="checkbox"/> SFMC Peoria |
| <input type="checkbox"/> SJMC Bloomington | <input type="checkbox"/> SLMC Kewanee | <input type="checkbox"/> SJJWAMAC Pontiac |
| <input type="checkbox"/> SHMC Danville | <input type="checkbox"/> SPMC Mendota | <input type="checkbox"/> SCMC Princeton |
| <input type="checkbox"/> SFH Escanaba | <input type="checkbox"/> HFMC Monmouth | <input type="checkbox"/> SAMC Rockford |
| <input type="checkbox"/> LCMMC Evergreen Park | <input type="checkbox"/> SEMC Ottawa / Streator | <input type="checkbox"/> HMMC Urbana |

Ministry-Wide Funds:

- | | |
|---|--|
| <input type="checkbox"/> Above & Beyond | <input type="checkbox"/> I am an OSF Nurse |
| <input type="checkbox"/> Home Care (Home Health, Hospice, Hospice Home) | <input type="checkbox"/> Innovation |
| <input type="checkbox"/> Mother Frances Krasse | |

General Funds:

- | | |
|--|---|
| <input type="checkbox"/> OSF HealthCare Cancer Institute | <input type="checkbox"/> SFMC CHOI Almost Home Kids |
| <input type="checkbox"/> LCMMC Mary Potter Crisis | <input type="checkbox"/> SFMC Children’s Hospital Area of Greatest Need |
| <input type="checkbox"/> SAMC Rockford Ascend Program | <input type="checkbox"/> SFMC Heller Center for Kids with Cancer |

This constitutes authorization for payroll deduction that will continue year to year until you are no longer with the organization or you notify the OSF Foundation in writing.

Signature: _____

Date: _____

Please send questions and completed forms by e-mail to: Jacob.D.Sexton@osfhealthcare.org

OR

Interdepartmental mail to: Foundation – OSF HealthCare Ministry Headquarters

Thank you very much for supporting the Mission!

For OSF Foundation Use Only:

Date Sent to Payroll:

Initials:

Fund ID:

Campaign:

Appeal:

Other Notes:

For OSF Payroll Use Only:

Pay Period:

Deduction Code(s):

Business Unit: