Med Center Health
Foundation

ECHO LIFE
EMPLOYEES CONTRIBUTING TO HELP OTHERS

100% of your gift CHANGES LIVES!

All administrative costs are funded by MedCenter Health.
Your donation is tax-deductible and will be listed at year end on your W-2.

SEND ORIGINAL FORM TO:
KATHY SMITH - MED CENTER HEALTH FOUNDATION

Name: _____ Employee #: _____
(Please print name as you want it to appear on donor listings.) ❑ Anonymous

Home Address: _____

City: _____ State: _____ Zip: _____

Entity: ❑ TMC at Bowling Green ❑ TMC at Scottsville ❑ TMC at Franklin ❑ TMC at Caverna ❑ TMC at Albany

❑ CHC ❑ CRSH **Department:** _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Yes, I want to support Med Center Health Foundation's mission through payroll deduction as indicated below:

❑ **NEW MEMBER**

Total Amount to be Deducted Per Pay Period:

❑ $1 per pay period ❑ $5 per pay period (High Five Club)
❑ $2 per pay period ❑ $10 per pay period (Top Ten Club)
❑ $3 per pay period ❑ $20 per pay period
❑ 1 hour of pay per pay period (Hour Club)

❑ **CURRENT MEMBER** (Pledge Amount: $_____)

❑ Increase Amount By:
❑ $1 per pay period ❑ $5 per pay period (High Five Club)
❑ $2 per pay period ❑ $10 per pay period (Top Ten Club)
❑ $3 per pay period ❑ $20 per pay period
❑ 1 hour of pay per pay period (Hour Club)

New Amount to be Deducted Per Pay Period: $_____

All donations will begin with the next pay period.

T-Shirt Size_____
(Anyone donating $5+ per pay period)

Gift Designation: (Required)

❑ The Community Clinic and The Dental Clinic
❑ Guardian Angel Children Services Program
❑ Hospitality House
❑ TMC Cancer Treatment Center
❑ TMC Health Sciences Complex Simulation Lab
❑ The Rebecca D. Shadowen Research & Education Fund
❑ Marion Boyd Scholarship Fund
❑ The Medical Center Bowling Green
❑ The Medical Center Scottsville
❑ The Medical Center Franklin
❑ The Medical Center Albany
❑ The Medical Center Caverna
❑ Cal Turner Rehab & Specialty Care
❑ Greatest Need

*More than one fund designation can be chosen and your donation will be split equally between them.

Signature _____ **Date** _____

For more information, call (270) 796–6519 or kasmith@mchealth.net

My signature confirms I will remain in the ECHO program for one year from the date above unless my employment shall cease. This deduction will remain in effect until I revoke in writing.

WHITE–Foundation YELLOW-Donor

28-973016 Rev. 04/21