

MY INFORMATION

NAME _____ EMPLOYEE ID _____

DEPARTMENT OR DIVISION _____

MAILSTOP _____

WORK EMAIL _____ WORK PHONE _____

AREAS OF SUPPORT

Connect your passion to your giving! You can direct your support to the below priority fund or another area at Northwest Hospital & Medical Center that is meaningful to you. Please visit supportuwmedicine.org/employee-northwest-hospital, or contact Gloria Chien at 206.543.5686 or give2uwm@uw.edu to learn about other areas to support.

- Northwest Hospital & Medical Center Fund for Greatest Need (NWMEDI)

MY GIVING

A. START A NEW PAYROLL DEDUCTION PLEDGE

Please consider starting a new payroll deduction pledge by filling in the information below. Please note: payroll deduction pledges renew every year, unless you instruct us otherwise. New payroll deduction pledges must be a minimum of \$1 per paycheck for a six-month duration (12 paychecks total). Please respond by June 7 so that new payroll deduction pledges — or changes to current ones — will take effect at the start of the fiscal year on July 13, 2018.

Fund Name	Total Pledge Amount (payments split over 26 paychecks)
	\$
	\$
	\$
	\$

Guide to Payroll Deduction Pledges

Annual gift of	Deducted per paycheck (26 pay periods or 1 year)
\$ 50	\$ 1.92
\$ 75	\$ 2.88
\$ 100	\$ 3.85
\$ 150	\$ 5.77
\$ 200	\$ 7.69
\$ 250	\$ 9.62
\$ 300	\$ 11.54
\$ 400	\$ 15.38
\$ 500	\$ 19.23
\$ 750	\$ 28.85
\$ 1,000	\$ 38.46
\$ 1,500	\$ 57.69
\$ 2,000	\$ 76.92
\$ 2,500	\$ 96.15
\$ 5,000	\$ 192.31

B. MAKE A ONE-TIME GIFT

Listed below are other funds you have supported in the past. Please use this section to indicate if you would like to make a new one-time gift to any of the funds listed, or to add a new fund you would like to support, and submit payment via check or credit card.

Fund Name	Yes, I'd like to make a one-time gift to this fund.
	\$
	\$
	\$

- I/we have enclosed a **CHECK**, made out to the University of Washington Foundation (tax I.D. 94-3079432).
- I/we prefer to pay by **CREDIT CARD**.
- Visa MasterCard American Express Discover

CARD NUMBER _____

EXP. DATE (MONTH/YEAR) _____ CVV CODE _____

FULL NAME ON CREDIT CARD _____

SIGNATURE (REQUIRED TO VALIDATE PAYMENT) _____

- Make this a monthly recurring gift. Gifts will be processed monthly until payment is canceled. \$5 minimum donation per month.

C. OTHER WAYS TO SUPPORT UW MEDICINE

- My spouse/partner's employer has a matching gift program. The form is enclosed.
- Tell me how I can include Northwest Hospital in my will/estate plan.
- I have included Northwest Hospital in my will/estate plan.

D. FINAL STEPS

When completed, please sign here: _____

Then return this form (and your check, if applicable) to: Employee Giving, UW Medicine Advancement, Box 358045, Seattle, WA 98195-8045.

FOR OFFICE USE ONLY APPEAL CODE: M18EE _____ Primary AID: _____ Secondary AID: _____

Other associated credit AID: _____ Allocation code: _____ Budget code: _____

UWM authorized by: _____ Date: _____