



Physician & Employee Campaign Giving Form

Name: _____ Title: _____ Department: _____
Home Address: _____
Cell Phone: _____ Office Phone: _____
Personal E-mail: _____ Office E-mail: _____

Gift Designation

- UH Fund (Area of Greatest Need)
- Other (UH medical center, institute, clinical program, etc.) _____
- * UH Event _____
*PER UH POLICY, ALL UH EVENT DONATIONS MUST BE PAID BY 2 MONTHS POST-EVENT
 Ticket(s) Table sponsorship(s) Donation In-Kind Donation

Payment Method

- Check (ENCLOSED MADE PAYABLE TO UNIVERSITY HOSPITALS) \$ _____
- Credit Card MasterCard Visa American Express Discover \$ _____
Card Number: _____ Exp. Date: ____/____/____
Name as it appears on card (PLEASE PRINT): _____

| | | |
|------------|----------------|-----------|
| FIRST NAME | MIDDLE INITIAL | LAST NAME |
|------------|----------------|-----------|
- Payroll Deduction (SELECT ONE):
 - One-time gift of \$ _____
 - Gift divided evenly over the year (26 PAY PERIODS FOR EMPLOYEES; 24 PAY PERIODS FOR PHYSICIANS AND LEADERS). Total gift of \$ _____
 - Recurring gift of \$ _____
(DEDUCT ABOVE AMOUNT EACH PAY PERIOD UNTIL DONOR CONTACTS INSTITUTIONAL RELATIONS & DEVELOPMENT TO DISCONTINUE DEDUCTIONS)
- *PLEASE NOTE THAT AS REFERENCED ABOVE, ALL UH EVENT DONATIONS MUST BE PAID BY 2 MONTHS POST-EVENT
- Other Payroll Deduction Schedule: _____

Recognition

- For recognition purposes, please list my/our name as indicated (PLEASE PRINT): _____
- I wish for my/our gift to remain anonymous.

I AUTHORIZE THIS GIFT AND AUTHORIZE THE FORM OF PAYMENT AS I HAVE DESIGNATED ABOVE.

Signature: _____ Date: ____/____/____

Additional Ways to Give

Call: 216-983-2200
E-mail: UHGiving@UHhospitals.org
Give Online: UHGiving.org/PECampaign
Interoffice Mail: University Hospitals Institutional Relations & Development -- MCCO 5062
Mail: University Hospitals Institutional Relations & Development, PO Box 94554, Cleveland, OH 44101-4554

