give a
BOOSTER SHOT
A CAMPAIGN OF THE VALLEY MEDICAL CENTER FOUNDATION

County of Santa Clara
Employee Payroll Deduction Form

To have your donation to the VMC Foundation "Give a Booster Shot" fundraising campaign automatically deducted from your paycheck, please complete this form.

Return form to the VMC Foundation: **FAX** (408) 885-5207 **PONY** 2400 Moorpark Ave #207
EMAIL SCANNED FORM debra.burdsall@hhs.sccgov.org

ALL PAYROLL DEDUCTIONS WILL BEGIN THE FIRST PAY PERIOD IN JANUARY, 2019.

PLEDGE INFORMATION

Yes, I want to be a Super Booster!

Deductions must be $8 or more per paycheck.

☐ I want to be a *Super Booster*. Please deduct $ _____ per paycheck until I ask you to stop.

Sorry, I can't be a Super Booster, but I can still make an important contribution.

☐ Please deduct $ _____ per paycheck until I reach a total donation of $ _____.

CONTACT INFORMATION

Please print clearly.

LEGAL NAME First : _____ Last : _____

Preferred First Name: _____ Job Title: _____

Employee ID Number: _____ ← *Refer to your most recent paycheck. Your employee ID is located in the center top box.*

Home Address: _____ City: _____ Zip: _____

Department: _____ PONY Address: _____

Personal Phone: _____ HHS/County Email Address: _____

Did another hospital employee encourage you to donate? If so, who? _____

CERTIFICATION

Please sign here **X** _____

VALLEY MEDICAL CENTER foundation
Helping Silicon Valley Care

The VMC Foundation is a non-profit charitable 501(c)(3) organization and your donation is tax deductible to the full extent of the law. No goods or services were provided in consideration of your gift. Your pledge will be processed as an unrestricted gift to the VMC Foundation through the system established by the Combined Giving Campaign of Santa Clara

For office use only: ☐ DP ☐ Scan ☐ SS

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VMC Foundation
Credit Card Donation Form

To have your donation to the VMC Foundation "Give a Booster Shot" fundraising campaign automatically deducted from your credit card, please complete this form.

Return form to the VMC Foundation: **FAX** (408) 885-5207 **PONY** 2400 Moorpark Ave #207
EMAIL SCANNED FORM debra.burdsall@hhs.sccgov.org

CREDIT CARD INFORMATION

Card Type (circle): VISA MC AMEX Card #: _____ Expiration Date: _____

Deducted: ☐ 1st of the Month ☐ 15th of the Month

PLEDGE INFORMATION

Yes, I want to be a Super Booster!

Deductions must be $28 or more per month for 3 years (36 months).

☐ I want to be a *Super Booster*. Please keep deducting $ _____ until I ask you to stop.

Sorry, I can't be a Super Booster, but I can still make an important contribution.

☐ Please deduct $ _____ until I reach a total donation of $ _____.

☐ Please make a one time donation of $ _____ .

CONTACT INFORMATION

Please print clearly.

NAME (as it appears on your card) First : _____ Last : _____

Job Title: _____ Dept: _____ PONY Address: _____

Billing Address: _____ City: _____ Zip: _____

Personal Phone: _____ Email Address: _____

Did another hospital employee encourage you to donate? If so, who? _____

CERTIFICATION

Please sign here **X** _____

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