THREE RIVERS COMMUNITY HOSPITAL FOUNDATION

PAYROLL DEDUCTION AUTHORIZATION

EMPLOYER:

Grants Pass School District 7

725 NE Dean Drive

Grants Pass OR 97526

EMPLOYEE:

____
Name

____
Last 4 of Social Security # AND phone #

____
Address

____
City, State Zip

☐ PAYROLL DEDUCTION

I would like to donate to ***Three Rivers Community Hospital*** a gift of:

$__________ per paycheck, effective ____________________.
(Date)

Date____________________Signature___________________________

All donated monies will be forwarded to:

Three Rivers Community Hospital Foundation
500 SW Ramsey Ave
Grants Pass, OR 97527

To begin deduction for the current pay period, this form must be received in the District Payroll Office no later that the 15th of the month. This agreement will remain in effect until the Employee terminates this agreement by submitting a request in writing.