



# Caring Together



## CMHS EMPLOYEE GIVING PROGRAM

### EMPLOYEE **PAYROLL DEDUCTION** PAYMENT AUTHORIZATION FORM

Yes! I would like to give through payroll deduction each pay period to Community Memorial Health System. I hereby authorize CMHS to make the following pre-tax withholdings from my payroll checks:

Employee Name \_\_\_\_\_

Employee Number \_\_\_\_\_ Department \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

#### GIVING OPTIONS

Please select one:

- Community Memorial Hospital
- Ojai Valley Community Hospital

I want to withdraw (check amount)  \$5  \$10  \$20 Other \_\_\_\_\_ from each pay period  
(Minimum payroll deduction is \$5.00)

I want to give a one-time gift \$ \_\_\_\_\_

Please make checks payable to **Community Memorial Healthcare Foundation** or by visiting online [www.CMHSEmployeeGiving.org](http://www.CMHSEmployeeGiving.org)

Signature \_\_\_\_\_

Please provide an ink signature

Date \_\_\_\_\_

Questions about the CMHS Employee Giving Program? Contact 805-948-2881 or [cmhf@cmhshealth.org](mailto:cmhf@cmhshealth.org)

#### Return this form to:

##### CMHS Inter-Office Envelope to:

Development Department/CMHF Office

##### Print, Sign, Scan & Email this form to:

[cmhf@cmhshealth.org](mailto:cmhf@cmhshealth.org)

##### Mail this form to:

Community Memorial Healthcare Foundation

2674 E. Main St. Suite E #210

Ventura, CA 93003

If you would like to make a change to the amount, or stop your payroll deduction, please contact the Development Office at 805-948-2881 or [cmhf@cmhshealth.org](mailto:cmhf@cmhshealth.org).



**Community Memorial  
Health System**