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***Statement of Intent to Give***

I would like to support the Employee Hardship Fund in the following manner:

🞎 Pledge payments billed bi-weekly through payroll deduction (26 paychecks annually):

*A minimum gift of $1/paycheck is required for payroll deduction.*

Total Pledged Gift Amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

$\_\_\_\_\_\_\_\_\_/per pay for the term of 🞎1 year 🞎2 years 🞎3 years 🞎4 years 🞎5 years

OR to end my pledge on pay date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I would like my pledge payments to begin in \_\_\_\_\_\_ (month) and \_\_\_\_\_\_ (year).

I would like to make a one-time payment in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by:

🞎 Check is enclosed. (Please make check payable to Sheppard & Enoch Pratt Foundation, Inc.)

🞎 Credit Card – please bill my: 🞎 Visa 🞎 MasterCard 🞎 American Express 🞎 Discover

Name as it appears on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 This gift is in 🞎 honor or 🞎 memory of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Please notify the following person of my gift:

|  |  |  |
| --- | --- | --- |
| Name: | | |
| Address: | | |
| City: | State: | Zip: |

***Recognition***

I would like to be recognized in the following way:

🞎 Please list my/our name(s) as:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Please check this box if you would like to remain anonymous.

***Contact Information***

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | | |
| Address: | | | |
| City: | State: | | Zip: |
| Phone: | | Email: | |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please return this form to:**

Paula Waters

Office of Philanthropy

Sheppard Pratt Health System, 6501 N. Charles Street, Baltimore, MD 21204

Phone: 410-938-4017 Fax: 410-938-4026

***Thank you for your support!***