



Contribution Form

Name: _____ Employee #: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: _____ Home Phone: _____ Campus: _____
Department: _____ Email: _____ Mail Stop: _____

*Donate a minimum of \$100 or 7 PTO hours and you'll receive a My Philanthropy Matters t-shirt!
T-shirts will be available for pick up at hospital. Please enter shirt size (S-3XL)*

Select the programs that you would like to contribute to:

A. Morton Plant Mease Health Care Foundation

Please select **one** fund you would like to contribute to:

| | | |
|-----------------------|-----------------------------|------------------------------------|
| Area of Greatest Need | Morton Plant | Jerry Massey Scholarship |
| Mease Countryside | Morton Plant North Bay | Cancer Care |
| Mease Dunedin | Nursing Excellence Campaign | Cardiac Care |
| | | Spirituality & Healing in Medicine |
| | | Peter Lloyd Perinatal Loss Fund |

Payment Method

Payroll deduction of \$ _____ per pay period for 26 pay periods (1 year) = \$ _____ (Deductions begin January 2023)

One Time Payroll Deduction in January 2024 in the amount of \$ _____

PTO donation of _____ hours (Deduction will occur in November 2023)

Cash gift of \$ _____ Check made payable to MPM Health Care Foundation for \$ _____

Credit Card gift of \$ _____ Card # _____ Expires _____ CVV: _____

B. Family Care Fund

Payment Method

Payroll deduction of \$ _____ per pay period for 26 pay periods (1 year) = \$ _____ (Deductions begin January 2023)

One Time Payroll Deduction in January 2024 in the amount of \$ _____

PTO donation of _____ hours (Deduction will occur in November 2023)

Cash gift of \$ _____ Check made payable to MPM Health Care Foundation for \$ _____

Credit Card gift of \$ _____ Card # _____ Expires _____ CVV: _____

C. United Way

Choose one: UW of Tampa Bay UW of Pasco County UW of Hernando County

Payment Method

Payroll deduction of \$ _____ per pay period for 26 pay periods (1 year) = \$ _____ (Deductions begin January 2023)

One Time Payroll Deduction in January 2024 in the amount of \$ _____

Cash gift of \$ _____ Check made payable to United Way for \$ _____

Credit Card gift of \$ _____ Card # _____ Expires _____ CVV: _____

Authorization (Must be signed or form will not be processed) Check one:
I authorize BayCare Health System to process my donation as requested, including payroll deduction if I have so indicated.
I do not wish to participate in the Caring for Our Community Team Member Giving Campaign.

Signature: _____ Date: _____

Return completed form to Morton Plant Mease Health Care Foundation, Mail Stop #116 or via email to MPMHCFoundation@baycare.org