HEALTHCARE HEROES DONATION FORM

DONOR INFORMATION

Name____

Address _

____

City/State/Zip ____

E-mail Address______________________________________Phone _________________________________

I would like to make a one-time donation to Healthcare Heroes in the amount of$ ___________________________

- ☐ Cash
- ☐ Check (Payable to Healthcare Heroes)
- ☐ Credit Card
  - ☐ Visa ☐ Master Card ☐ Amex ☐ Discover

____
Card Holder Name

____
Card Number

____________________ ____________________
V Code *Expiration Date*

____
Signature

ACKNOWLEDMENT *(optional)*

☐ In Memory of ____________________________________

☐ In Honor of ______________________________________

☐ Please send acknowledgement of donation to:

Name____

Address ____

City/State/Zip ____________________________________

PAYROLL DEDUCTION

I would like to donate $ _________________
per pay period *(minimum $1.00 per pay period)*.

☐ New deduction
☐ Change existing payroll deduction:
☐ Increase ☐ Decrease

Employee ID Number ______________________

Department_______________________________

Authorization
I hereby authorize the Controller of San Mateo County to deduct $_______________from my earnings each bi-weekly pay period. This authorization shall remain in effect until change is given by written notice from the employee to the Controller's office.

____
Employee Signature

For further information, please call (650) 573-2655 or email lwilliams-hurt@smcgov.org

DONOR RECOGNITION *(optional)*

☐ I would like to be listed in the contribution list as ___________________________________
☐ Please do not publish my name on the contribution list.

Received By_______________________Date _____________

Tax ID# 94-3116070

Please send completed donation form to:

San Mateo County Health Foundation
222 West 39th Avenue, San Mateo, CA 94403
Fax: (650) 573-3447, PONY # HOS316 Foundation