New Lakeland Medical Center Pavilion
ASSOCIATE CAMPAIGN

Lakeland Health Foundations

This is to confirm that I/we intend to contribute the sum of $ _____ to the New Lakeland Medical Center Pavilion

PAYROLL DEDUCTION:

❒ Please initiate payroll deductions in the amount of $ _____ per pay period for _____ pay periods upon receipt of this form, or beginning _____

NON PAYROLL PLEDGE:

❒ Please record my pledge of $ _____ to be paid by check or cash, please bill me:
❒ Annually ❒ Semi-annually ❒ Quarterly ❒ Monthly Beginning _____

ONE TIME PAYMENT:

❒ Please record my immediate contribution of $ _____
❒ Check Enclosed ❒ Credit Card (enter information below)

❒ Visa number _____ Exp. date _____
❒ Mastercard number _____ Exp. Date _____

Name(s): _____
(As you would like it to appear on acknowledgments)

Associate ID Number: _____ Department: _____
(Needed for payfoll deduction only) *(Please print)*

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Signature: _____ Date: _____

Thank you for your generosity!

Your gift is tax deductible.
This pledge indicates my intent and is non-binding.

White copy: Donor *Yellow & pink copies: Lakeland Health Foundations*