



Circle of Compassion Team Member Donation Form

PLEASE FILL OUT YOUR REQUIRED PERSONAL INFORMATION:

Employee #: _____ Department: _____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Signature Required: _____ Date: _____

PAYMENT OPTIONS:

1. Recurring payroll deduction for your convenience: Your donation will continue to be deducted from your paycheck each pay period until you request it be stopped or indicate a stop date below.

- \$2 per pay = \$52 yearly
- \$4 per pay = \$104 yearly
- \$5 per pay = \$130 yearly
- \$7.50 per pay = \$195 yearly
- \$15 per pay = \$390 yearly
- \$20 per pay = \$520 yearly
- \$25 per pay = \$650 yearly
- \$30 per pay = \$780 yearly
- \$40 per pay = \$1,040 yearly
- \$50 per pay = \$1,300 yearly
- \$75 per pay = \$1,950 yearly
- \$100 per pay = \$2,600 yearly

Please stop my payroll deduction after _____ year(s). If this box is not checked, your payroll deduction will carry over each year until you notify the foundation.

2. One-time gift by check in the amount of \$ _____ to:

Circle of Compassion Fund
1340 Campus Parkway, Suite C-4
Neptune, NJ 07753

3. Credit card: Please visit www.hackensackmeridianhealth.org/CircleOfCompassion to pay with a credit card online.

**Please complete and sign this form then email to
Giving@hackensackmeridian.org.**

If you are unable to print and return this form, please send your team member ID, amount to be deducted each pay period, and your home address to the foundation at Giving@hackensackmeridian.org