

## Contribution by Payroll Deduction Authorization

Employee	Name:				
Home Add	ress:				
City:		State:	Zip Co	ode:	
Email Add	ress:	Pho	ne:		
Employee	Number:	Department Name	e:		
Hospital/D	epartment Number:				
until the s <sub>l</sub>	e the following amount to becified goal amount is r arolina School of Medici	eached. I understand th	nat my deducti		
	Bi-weekly Deduction An	nount: \$	·		
	One-time Deduction An	nount: \$	·		
	Total An	nount: \$	·		
For more i Giving@gh	nformation, contact the ns.org.	Office of Philanthropy a	and Partnershi	p at (864) 797	'-7736 or
Employee	Signature:			Date:	
Fo	r Payroll Use Only				
No	o. 55 GHS FUND 09 Fre	q AMOUNT\$	. GOAL	\$	Utility 0000100