Membership
Voluntary Deduction Form

Clay County Hospital
FOUNDATION

☐ PLEDGE

I, _____ authorize the Clay County Medical Center to deduct:

□ $2.00 from each pay check for a total of $500.00.

□ $4.00 from each pay check for a total of $500.00.

□ $5.00 from each pay check for a total of $500.00.

□ $10.00 from each pay check for a total of $500.00.

□ $20.00 from each pay check for a total of $500.00.

□ Other _____ from each pay check for a total of $500.00.

- All contributions to the Clay County Hospital Foundation are tax-deductible to the extent allowed by law.

☐ MEMBER INFORMATION

Name:_____ Spouse:_____

Address: _____

City, State: _____ Zip Code: _____

Phone: _____

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____