Hartford HealthCARES
Where we work. Where we live. Where we give.

Central Region Colleague Giving Form

Your donation remains at the hospital selected to support your family, community and our patients.

Name: _____ Employee ID#:_____
Address:_____City_____ ST____ Zip_____
Department:_____Phone Number:_____

STEP 1: CHOOSE THE HOSPITAL(S) YOU WISH TO DONATE TO

☐ **MIDSTATE MEDICAL CENTER**
☐ **THE HOSPITAL OF CENTRAL CONNECTICUT**

STEP 2: CHOOSE A PAYMENT METHOD

A. PAYROLL DEDUCTION (minimum of $2 per pay period)

☐ Deduct **$**_____ bi-weekly from my paycheck until I inform you otherwise

B. ONE-TIME GIFT

☐ Check Enclosed **$**_____ (Payable to the hospital entity)
☐ Credit Card **$**_____ Circle One: *MasterCard Visa Discover AmEx*

*Credit Card Number*_____ *Exp. Date* _____ *Security Code*_____

STEP 3: GIFT DESIGNATION (optional)

UNLESS OTHERWISE MARKED, YOUR GIFT WILL GO TO THE AREAS OF GREATEST NEED

MIDSTATE MEDICAL CENTER	**THE HOSPITAL OF CENTRAL CONNECTICUT**
__ **AREAS OF GREATEST NEED** __ Breast Cancer Early Detection __ Cancer Center __ Jill Bertolini Fund __ Nursing Education __ Patient Assistance __ Other _____	__ **AREAS OF GREATEST NEED** __ Breast Cancer Early Detection __ Behavioral Health __ Cancer Center – George Bray __ Jill Bertolini Fund __ Nursing Education __ Patient Assistance __ Other _____

STEP 4: SIGN, DATE AND RETURN FORM

Signature _____ **Date:** _____
Signature and date required to process request

INTEROFFICE OR SCAN FORM OR CALL 860.224.5685
JENNIFER MILARDO, PHILANTHROPY DEPARTMENT OR
JENNIFER.MILARDO@HHCHEALTH.ORG

ONLINE GIVING: *THOCC.org/donate* or *midstatemedical.org/donate*