

Employee Emergency Fund Bi Weekly Payroll Deduction Authorization Form

Last Name : _____ First Name: _____ MI: _____

Facility: _____

Phone: _____

Employee Signature (required)

Date: _____

Choose ONE only:

NEW Biweekly deduction – continuous NEW Biweekly deduction w/Goal Limit

REPLACEMENT for Existing Deduction CANCELLATION Deduction

I wish to support the Acuity Healthcare Employee Emergency Fund. I understand that this authorization for Payroll Deduction will remain in effect until employment separation, or the pledge is paid off or cancelled by me in writing.

I Authorize the Following Payroll Deduction

Bi-Weekly Deduction of \$ _____ until my Total Pledge of \$ _____ is fulfilled. (Enter Goal Limit)

Designate my gift to support: Acuity Healthcare Employee Emergency Fund

Please complete the above information and return this form to: Human Resources

NOTE: Deduction forms will be processed immediately upon receipt by Corporate Payroll. Because of Payroll processing requirements and deadlines, this payroll deduction may take up to two (2) pay periods to begin.