



Bon Secours St. Francis Foundation

I wish to join others in support of the ministry of Bon Secours St. Francis Health System with the following gift:

Name _____

Address _____

City _____ State/Zip _____

Telephone (_____) _____ Email: _____

Signature _____ Date _____

- I would like someone from the St. Francis Foundation to contact me about giving.
- I/We pledge a total of \$_____ to be paid over _____ year(s), with payments beginning _____; ending date of pledge _____.
- A check is enclosed payable to the St. Francis Foundation in the amount of \$_____.
- I wish this gift to remain anonymous.
- My gift will be matched by _____
- I give my permission to be recognized in publications and wish my name to appear as follows:

- I wish to honor or memorialize (please circle one) the following named individuals:

- I wish to honor a caregiver through the Guardian Angel program:

- I would like more information about becoming a St. Francis volunteer.
- I do not wish to give at this time and please remove me from future solicitations.

Please designate my gift to:

<input type="checkbox"/> St. Francis Foundation Unrestricted Fund	<input type="checkbox"/> Cardiovascular Services/Heart Fund
<input type="checkbox"/> Louis P. Batson, Jr. Patient Support Fund	<input type="checkbox"/> Mack Pazdan Neonatal Care Center
<input type="checkbox"/> AYA Cancer Inpatient Care Center	<input type="checkbox"/> Pearlie Harris Breast Health Center
<input type="checkbox"/> Open Arms Hospice	<input type="checkbox"/> Other: _____

All gifts to the St. Francis Foundation are tax deductible as provided by law.



ST. FRANCIS FOUNDATION
Bon Secours St. Francis Health System

Debit Authorization

I (we) hereby authorize Bon Secours St. Francis Foundation, hereinafter called Company, to initiate debit entries to my (our) account indicated below and the financial institution named below, hereinafter called Financial Institution, to debit the same to such account for (Application). I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provision of the U.S. law.

Financial Institution

Branch

Address

City/State/Zip

Routing Number

Account Number

Type of Account: _____ Checking _____ Savings

Amount (or how much is determined) _____

Frequency (Weekly, Monthly, etc.): _____ Start Date (if recurring): _____

Date of Debit(s): _____

If this debit is recurring and the date of the debit falls on a non-banking day, the debit will hit your account on the next banking day and will not hit your account prior to the authorized date.

(Note: For varying amounts the company must sent, based on the *NACHA Operating Rules*, written notification of the amount and the date on or after which the transfer will be debited at least ten calendar days in advance of the debit. If the date varies, the *Rules* state that the Originator must sent the Receiver notification of new date at least seven calendar days in advance of the debit.)

This authority is to remain in full force and effect until Company has [*received written notification from me (or either of us) or describe your process for revocation of the authorization*] of its termination in such time and manner as to afford Company and Financial Institution a reasonable opportunity to act on it.

Print or Type Individual Name

Signature

Date