



**Riley Hospital Internal Campaign
Clarian Health Partners Payroll Deduction Form**
Required for those making a gift using Clarian Payroll Deduction

Employee Information

Name: _____

Employee ID #: _____

Department: _____

Hospital: _____ Building: _____ Room #: _____

Gift Information

3 Options (Choose one)

I wish to make a gift through Clarian payroll deduction of \$_____ per pay period for 26 pay periods beginning _____ (month) _____ (year):

Total gift amount: \$ _____

I wish to make a gift through Clarian payroll deduction of \$_____ per pay period for 13 pay periods beginning _____ (month) _____ (year):

Total gift amount: \$ _____

I wish to make a one time gift through Clarian payroll deduction of \$_____ for the pay period beginning _____ (mm/dd/yyyy).

To specify gift direction, please use the Riley Children's Foundation Commitment/Pledge Form.

Employee authorizes Clarian Health Partners to deduct and withhold payroll deduction from each biweekly pay until the entire gift amount has been paid.

The employee may revoke this authorization at any time by providing Clarian Health Partners Payroll Department 950 North Meridian Street Suite 1200 Indianapolis, Indiana 46204 and the Riley Children's Foundation Gift Processing Department 30 South Meridian Street Suite 200 Indianapolis, Indiana 46204 with written notification.

This agreement has been executed in duplicate, and an executed copy has been furnished to the Employee and Clarian Health Partners. No goods or services have been provided in connection with this gift.

IN WITNESS WHEREOF, the parties have executed this payroll deduction on _____, 200_.

Employee Signature (required): _____