



**COLLEGE OF ALLIED HEALTH SCIENCES**  
**Faculty & Staff Gift Form**

I wish to support the East Carolina University College of Allied Health Sciences by contributing to the East Carolina University Medical & Health Sciences Foundation, Inc.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
 Street City State Zip

**Please designate my gift of \$ \_\_\_\_\_ to:**

- |   |   |
|---|---|
| <input type="checkbox"/> Annual Fund (Dean's Alliance for Excellence – Leadership Initiative) | <input type="checkbox"/> Department of Health Services and Information Management |
| <input type="checkbox"/> Scholarship (specify name or general) _____                          | <input type="checkbox"/> Department of Occupational Therapy                       |
| <input type="checkbox"/> Endowment (specify name) _____                                       | <input type="checkbox"/> Department of Physical Therapy                           |
| <input type="checkbox"/> Department of Biostatistics  | <input type="checkbox"/> Department of Physician Assistant Studies                |
| <input type="checkbox"/> Department of Clinical Laboratory Science                            | <input type="checkbox"/> Department of Rehabilitation Studies                     |
| <input type="checkbox"/> Department of Communication Sciences and Disorders                   | <input type="checkbox"/> Other _____  |

**Payment method:**

- Payroll Deduction (please use form below)
- Check enclosed – payable to the ECU Medical & Health Sciences Foundation, Inc.
- Please bill me – specify billing date(s) \_\_\_\_\_
- Charge my credit card:
- |   |                                     |                               |                 |
|---|-------------------------------------|-------------------------------|-----------------|
| <input type="checkbox"/> American Express | <input type="checkbox"/> MasterCard | <input type="checkbox"/> Visa | Amount \$ _____ |
| Card Number _____                         |                                     | Expiration Date _____         |                 |

Signature \_\_\_\_\_ Date \_\_\_\_\_

I would prefer to be contacted by the Development Officer for the College of Allied Health Sciences

**Payroll Deduction Authorization**

Name \_\_\_\_\_ Banner ID # \_\_\_\_\_  
 (as it appears on paycheck)

Campus Address \_\_\_\_\_ Phone \_\_\_\_\_

Amount\* \_\_\_\_\_

*\*Remember there are two pay periods per month. To figure the amount you wish to give using the payroll deduction plan, divide your total annual gift by 24 and write this number in the space above. Example: \$240 annual gift divided by 24 pay periods = \$10 per pay period.*

**Please check appropriate block:**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Initial payroll deduction   | Per pay period (minimum \$5) \$ _____ |
| <input type="checkbox"/> Change in payroll deduction | Monthly total \$ _____                |
| <input type="checkbox"/> Cancellation of deduction   |                                       |

I would like this action to begin on \_\_\_\_\_  
 (Month-Day-Year)

I hereby authorize payroll deduction on a bi-monthly basis for the amount indicated for the ECU Medical & Health Sciences Foundation, Inc. This authorization shall continue until cancelled by me upon written notice to the ECU Medical & Health Sciences Foundation, Inc.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Return completed form along with payment or deduction information to: The ECU Medical & Health Sciences Foundation, Inc.  
 Attn: Patrice M. Frede • ADI Building • 525 Moye Boulevard • Greenville, NC 27834 • 252-744-2238 office • 252-744-3261 fax

*No goods or services are provided in whole or in partial consideration for payroll contributions*

**EVERY gift makes a difference ~ THANK YOU for your generosity!**