Through the strong support and financial contributions of the *1875 Founders Society*, the Healthcare System is able to continue to offer convenient access to advanced technologies and leading-edge services – all in a compassionate environment. We invite you to become a member of the *1875 Founders Society* to continue the great work of our founding Franciscan Sisters.

Through your annual $5,000 or more contribution, you will have the opportunity to direct your gift to the fund of your choosing. You may choose to remain a member of the *1875 Founders Society* by making annual contributions of $5,000 or more to the Saint Francis Foundation for five years or until you reach Lifetime Member status at $25,000 or more. Members will receive an exclusive invitation to attend the annual Grace Notes major donor appreciation dinner and be recognized on the donor wall located in the Saint Francis Medical Center Tower Lobby.

## 2019 COMMITMENT FORM

**I am making a commitment to be a member of the *1875 Founders Society*.**

Recognition Name: ________________________________________________________________

Mailing Address: _________________________________________________________________

Email: ____________________________________ Telephone: ____________________________________

**Donation Amount:** _____________ *(Annual Minimum 1875 Donation/Receipt Total: $5,000)*

**Please restrict my donation to:** □ Area of Greatest Need □ CancerCare □ CardiacCare □ Chapel □ Dig for Life □ Friends □ Hospice □ #JoyChallenge □ Parents With Hope □ Other: _____________

**I wish to support the following Saint Francis Foundation Events or Campaign:**
□ 2019 Friends Gala □ 2019 Friends Golf □ 2019 Pink Up □ 2019 Year End
Please note: Receipt total is less any benefit(s) received including tickets, golfer registration fees, etc.

## BILLING INFORMATION

Please charge my: □ Master Card □ Visa □ Discover □ American Express

Account #: ____________________________ Expiration Date: __________ CVC # _________ (3 digit code)

Billing Address: ________________________________________ City/State/Zip: _______________________

Signature of Cardholder: ____________________________________________________________________

Enclosed is my check for $______________ Check #: _____________ Payable to: **Saint Francis Foundation**

## 2019 PAYROLL DEDUCTION REQUEST (IF APPLICABLE)

**I, hereby authorize my employer (Saint Francis Healthcare System) to deduct: $**________ per pay period from my pay until a total of $_____________ which I owe is paid in full. The first deduction is to begin on or about __________.

Colleague #: ____________ Colleague Signature: ________________________________

**Please forward completed form to:**

211 Saint Francis Drive, Cape Girardeau, MO 63703
Phone (573) 331-5790 Fax (573) 331-5075 Email dtorbet@sfmc.net

**Thanks for your generosity and support!**