THE UNIVERSITY OF MICHIGAN
EMPLOYEE GIFT PAYROLL DEDUCTION FORM
(PLEASE TYPE OR PRINT)

U/M ID# (REQUIRED)

LAST NAME FIRST NAME INITIAL

HOME ADDRESS ____________________________________________________________________________________

______________________________________________________________________________________________

City State Zip

WORK PHONE: __________________________ EMAIL: ____________________________

I AUTHORIZE THE FOLLOWING:

TOTAL GIFT OF: $ __________________________

PAYROLL DEDUCTION OF: $ _________ PER MONTH ($5 MINIMUM)

NUMBER OF MONTHS (5 MONTH MINIMUM)

BEGINNING: MONTH __________ YEAR ______

GIFT DESIGNATED TO FUND: _________________________________________________________________

SIGNATURE: ___________________________________________ DATE: _________________________

(REQUIRED)

PLEASE SEND COMPLETED FORMS TO:

LORI HIRSHMAN
INTERIM DIRECTOR OF DEVELOPMENT
DEPARTMENT OF INTERNAL MEDICINE
OFFICE OF DEVELOPMENT
1000 OAKBROOK DRIVE, SUITE 100
ANN ARBOR, MI 48104
SPC 6796
PHONE: 734-763-6080

FOR UNIT DEVELOPMENT OFFICE USE:

Unit Contact Person Name ___________________________ Phone ___________________________ Email ___________________________

LOOKUP ID ___________________________ MARKETING EFFORT ___________________________

PLEDGE ID ___________________________ TOTAL PLEDGE AMT ___________________________

DART DESIGNATION # ___________________________ PREMIUM DOLLAR AMT ___________________________