



CREATING A HEALTHIER FUTURE FOR ALL

JOIN YOUR COLLEAGUES BY INVESTING IN CARING, HEALING, TEACHING, SERVING ALL. CREATE A DEEPER IMPACT YEAR-ROUND!

Alameda Health System plays a vital role in serving Alameda County's health care needs thanks to the passion, commitment, and care of physicians and staff like YOU.

Your gift today helps to sustain programs and services year-round that positively impact whole person care for the whole community.

WAYS TO GIVE

Check
Credit Card
Payroll Deduction
Paid Time Off (PTO)



Scan the QR Code or return this form to: Alameda Health System Foundation, 55 Harrison Street, Suite 600, Oakland, CA 94607 or by email to ahsfoundation@alamedahealthsystem.org.

FoundationAHS.org/AHSCares



YES! I want to help Alameda Health System continue to improve health outcomes and well-being!

Name: _____

Mailing Address: _____

Email Address: _____ Daytime Phone: _____

AHS Location: _____ Department/Unit: _____

PAYROLL I pledge to support through AHS Payroll.

Minimum: \$10 per pay period

Recurring | *Make an impact all year-round!*

\$ _____ per pay period

UNTIL: I cancel OR end on: _____

One-Time Gift

\$ _____ payroll deduction OR _____ hours PTO

Signature: _____ Date: _____

By signing, you authorize AHS Payroll to automatically process your gift according to the terms selected above. For bi-weekly gifts via Payroll Deduction, this agreement shall remain in effect until revoked by you through a written request to AHS Foundation, allowing 30 days to process the request. Employees making a PTO gift must have a balance of PTO available to fulfill their pledge after required deductions including those legally required when cashing out PTO, and may be contacted by AHS Payroll Services for additional information.

CHECK / CREDIT CARD or DONATE ONLINE: FoundationAHS.org/AHSCares

Check (Payable to Alameda Health System Foundation)

Monthly Recurring

Visa Mastercard American Express

Make an impact all year-round!

Card Number: _____ Exp: _____ CVV: _____

Name on Card: _____ Amount: _____

Signature: _____ Date: _____

PLEASE CHECK ALL THAT APPLY

Please designate my gift to:

Area of greatest need

I would like my gift to be anonymous

Addressing unmet social needs

I have included AHS Foundation in my estate plans.

Increasing access to quality care

I would like to leave a legacy gift. Please contact me.

Building a community-centered workforce

I am interested in volunteer opportunities.

Other:

My gift is in honor of in memory of:

Name: _____

Please send notification of my gift to:



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