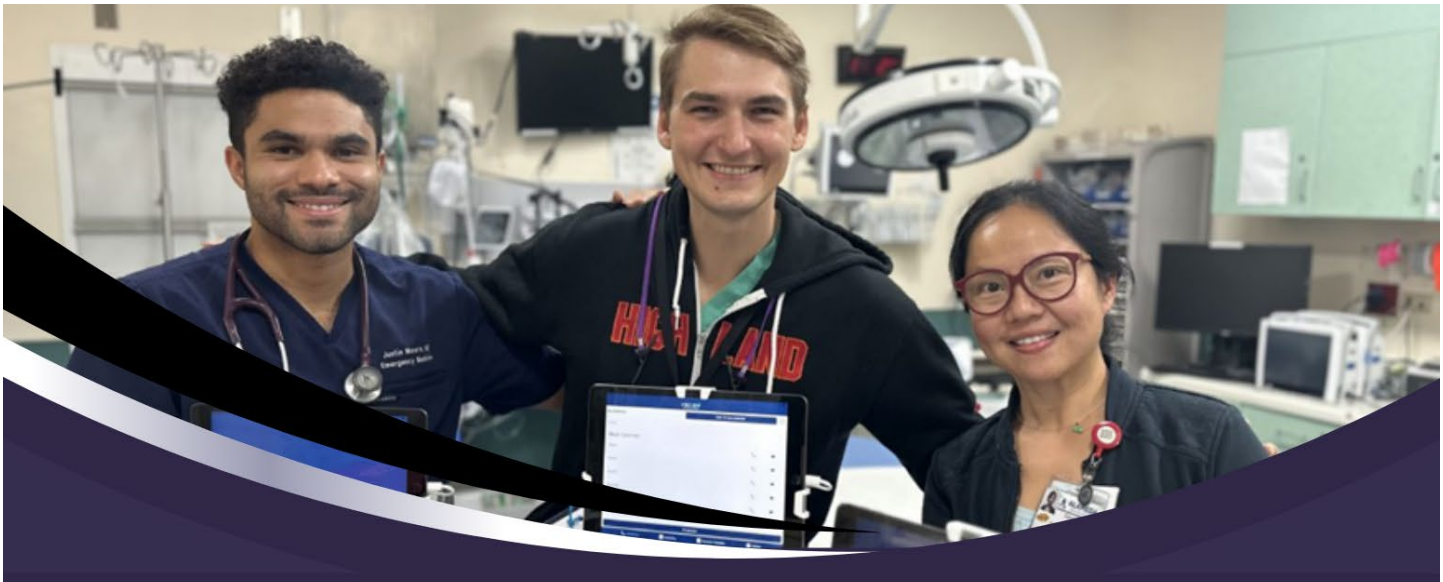

ADVANCING HEALTH EQUITY TOGETHER

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

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

ALAMEDA HEALTH SYSTEM FOUNDATION

YES! I want to help Alameda Health System continue advancing health equity!

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
Make an impact all year-round!

☐ Visa ☐ Mastercard ☐ American Express

Card Number: _____ Exp: _____ CVV: _____

Name on Card: _____

Signature: _____ Date: _____

PLEASE CHECK ALL THAT APPLY

Please designate my gift to:

☐ Area of greatest need

☐ Addressing unmet social needs

☐ Increasing access to quality care

☐ Building a community-centered workforce

☐ AHS Location or Program:

☐ I would like my gift to be anonymous

☐ I have included AHS Foundation in my estate plans.

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

☐ I am interested in volunteer opportunities.

☐ My gift is ☐ in honor of ☐ in memory of:

Name: _____

Please send notification of my gift to:

_____

_____

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FoundationAHS.org/AHSCares

ALAMEDA HEALTH SYSTEM FOUNDATION