



## Nova Scotia Health Authority - Staff Payroll Deduction Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (h) \_\_\_\_\_ (w) \_\_\_\_\_

Email: \_\_\_\_\_

Department: \_\_\_\_\_ Employee Number: \_\_\_\_\_

**I am pleased to commit to the Employee Payroll Deduction Program.**

The deduction amount shall be: \_\_\_\_\_ each pay period.

Date of first deduction: \_\_\_\_\_

I am designating my gift to: Area of Greatest Need

Other: \_\_\_\_\_

Please list department or area.

*For more, please contact the Cape Breton Regional Hospital Foundation at 567-7752*

**Important, please read:** *This deduction will continue until changed or cancelled by the employee through submission of an amended payroll authorization form.*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Thank you for your support!***