Mount Sinai
MEDICAL CENTER
Your Health. Our Mission.

Authorization Form

By my signature below, I hereby authorize Mount Sinai Medical Center to deduct the specified donation amount from my paycheck as indicated below. This authorization will remain in effect until I submit written notice to cancel or modify my donation, which must be provided at least 30 days before the next scheduled deduction. Participation in this program is completely voluntary and will not impact my employment status or benefits. My personal and payroll information will be kept confidential and will be used solely to process my donation. I understand that deductions already processed cannot be refunded. This authorization complies with all applicable state and federal laws regarding payroll deductions.

Employee Name	
Employee Number	
Department Name	
Email	
Mobile Number	
Donation Amount	
One-Time or Recurring Monthly	**(Circle One): One-Time or Recurring**
Frequency of Recurring Gift	**(Circle One): Bi-Weekly or Monthly**
In Honor of / In Memory of	
Employee Signature	
Date	

Mount Sinai Medical Center Foundation Contact Information

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