



**1. Personal Information**

Name: \_\_\_\_\_ Supervisor (if applicable): \_\_\_\_\_

Employee ID: (if applicable) \_\_\_\_\_ Department: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Name as you wish to be listed in public recognition (e.g. Foundation Annual Report, donor wall, newsletters)

I would like to remain anonymous. I understand my name will not be listed in public recognition.

**Yes, I want to join the St. Mary's Health System Medical Staff Giving Circle**

Minimum annual gift to become a member of Medical Staff Giving Circle for MDs and DOs is \$1,000.

Minimum annual gift to become a member for Advanced Practice Providers is \$500.

**2. Gift Details**

**Please designate my gift to the St. Mary's Health System Medical Staff Giving Circle Fund**

I would like to make my gift by:

**Payroll Deduction** (only available for employed medical staff)

\$50  \$25  Other \$ \_\_\_\_\_ per pay period for the duration of:

12 months (first pay period May 2026 through last pay period April 2027)

24 months (first pay period May 2026 through last pay period April 2028)

36 months (first pay period May 2026 through last pay period April 2029)

**Pay Frequency**  Semi-monthly (twice month)  Bi-weekly (every other week)

**One-time Annually Payroll Deduction** in amount of:  \$500  \$1,000  Other \$ \_\_\_\_\_

One-time annually payroll deduction for the duration of:

One year (May 2026)  Two years (May 2025, 2027)  Three years (May 2026, 2027, 2028)

**Cash/Check:** Payable to St. Mary's Health System. Enclose with form. Return address below.

**Credit Card:** Give securely online at:  
[stmarysmaine.com/support-st-marys/  
medical-staff-giving-donation-form/](http://stmarysmaine.com/support-st-marys/medical-staff-giving-donation-form/)



**Questions?**

Please contact Deb Anthoine  
207-777-8828  
danthoine@covh.org

**Contact our office if you wish to make a multiple year  
pledge to be paid by check or with credit card.**

Return forms through  
interoffice mail or by U.S. mail:  
St. Mary's Health System Foundation  
PO Box 7291  
Lewiston, ME 04243

**3. Please sign**

Signature \_\_\_\_\_ Date \_\_\_\_\_