Print Name: ______________________________

Department: ______________________________

Campus Location: ______________________________

Phone Number: ______________________________

Email: ______________________________

Home Address: ______________________________

____

The ***dream team member*** who referred me is ______________________________

☐ Yes, I would like to ***dream*** with you.
(Please choose the amount you would like to contribute to your designated dream area)

- ☐ 1 hour of my hourly wage per pay period
- ☐ 1/2 hour of my hourly wage per pay period
- ☐ $10.00 per pay period
- ☐ $______ per pay period

☐ I am not interested in giving at this time, but I do have ***time to give*** as a volunteer.
(We ask for a 6 month commitment, please)

- ☐ 1 shift per month (4 hrs)
- ☐ 2 shifts per month (8 hrs)
- ☐ 3 shifts per month (12 hrs)
- ☐ 4 shifts per month (16 hrs)
- ☐ I would like to become a regular volunteer

My ***dream will be fulfilled*** through my contributions toward ______________________________
(Please see below for gift designation options. If something is not listed that you would like your contribution to go toward, call Ashley at 844-8240)

Area of Greatest Need

Acute Rehab
Appearance Center
Asthma Clinic
Bed Addition
Cancer Center Education
Carson Cancer Center
Carson Cancer Center Van
Cardiac Services
Cardio Pulmonary Rehab
Child Advocacy Center
Clinical Decision Unit
Diabetic Center
Dialysis
Education
- Employee & Medical Staff
- Internships
- Patient Education
Emergency Room
Endowments
- Area of Greatest Need
- Carson Cancer Center
- Cardiac Services
- Dialysis
- Education
- Hospice
- St. Joseph's/Skyview Villa
Guest Services
Healing Garden
Health Resource Center
Home Health
Hospice
Intensive Care Unit
Mammography
Nursery
Nursing Services
Nutrition Services
- Meals for Families
Obstetrics
Orthopedics Unit
Outpatient Clinic
Palliative Care
Pediatrics
Performance Improvement
Psychiatric Services
Radiology
Recovery Room
Rehab Central
Respiratory Therapy
Scholarships
- Radiology & Nursing
Social Services
Spiritual Care
Surgical Services

I authorize the above indicated contribution to the Dream Team. I understand that at any time I can upgrade, downgrade or cancel my membership in the Dream Team. Depending on gift level, a portion of my gift is tax deductible.

Signature: ______________________________ Date: ______________________________

☐ Yes, you have my permission to use my name in hospital publications. ☐ No, I wish to remain anonymous.