**Springfield Education Foundation**
PO Box 663
Springfield OR • 97477
541-726-3243
christina@springfieldeducationfoundation.org

# MONTHLY DONOR AUTHORIZATION FORM
# SPRINGFIELD PUBLIC SCHOOLS PAYROLL DEDUCTION

**Name:** _____

**Address:** _____

**City:** _____**Zip:** _____

**Email:** _____

**Phone:** _____

**For: Authorization Agreements for Monthly Donations via SPS Payroll**

I authorize Springfield Public Schools to withdrawal **$**_____ **per month from my payroll to support** _____ **(SEF, school or program of your choice) to the Springfield Education Foundation.**

This authorization is to remain in effect until the Springfield Education Foundation has received written notification from me to terminate. I will allow for sufficient time for the Springfield Education Foundation a reasonable opportunity to stop payments.

I am aware to change the date, amount or skip a monthly donation I will contact the Springfield Education Foundation five working days before the scheduled entry date.

Signature: _____Date: _____

Please submit completed form to kim.donaghe@springfield.k12.or.us