Windsor Regional Hospital Foundation
Circle of Care Campaign

PLEDGE ALTERATION FORM

Date: _____

Name: _____

Department: _____

Phone Ext: _____

Action Requested: (please check below)

- ☐ **ADJUSTMENT:** I wish to change my current payroll deduction from $ _____ per pay to $ _____ per pay.

- ☐ **CANCELLATION:** I wish to cancel my contribution.

  Reason? _____

Comments: _____

Signature: _____