



PAYROLL DEDUCTION FORM

Please fill out this form completely.

OHSU is making it possible for employees to participate in a payroll deduction program for the payment of their OHSU hospital account.

I hereby agree to have the below payment deducted through my OHSU Paycheck. I understand the payment will be taken out of the pay periods I have indicated below. This payment is not a pre-tax deduction; but will be taken after taxes. **Print, sign, and fax this form to Patient Business Services at (503) 494-4546.**

Employee Name: _____

Employee ID#: _____

Today's Date: _____

Bi-Weekly Payment Amount: _____

Total Amount To Be Deducted: _____

Pay Period(s): _____

(Payments will not be deducted on the 3rd pay period of the month. Enter pay period and/or pay periods separated by commas. For example: 1, 3, 8-10)

Patient Account #: _____

Patient Name: _____
(If different than employee name)

Print Full Name: _____

Signature: _____

(Acknowledges a full understanding of instructions)