



Payroll Deduction Form for Bell Hospital Logo Wear

Please fill out this form, attach it to a printout of your order and forward it to Human Resources.

By signing below, I authorize Bell Hospital to deduct the sum listed from my paycheck commencing with the next pay period. I authorize Bell Hospital to deduct any remaining balance due from my final paycheck. I further understand any balance not covered by the payroll deduction will be my responsibility and due to Bell Hospital within thirty (30) days of my termination.

Date: _____

Employee # _____

Employee Name (print) _____

Employee Signature _____

Total Cost:

\$ _____

Split between how many pay periods? 1 2
(dollar amount must exceed \$25.00 or more in order to be split)

For questions on payroll deduction contact Cathy Martin ,
906-485-2719 cathy.martin@bellmi.org

For questions on your order contact Ann Halverson, CareWear@Prizepromos.com
608-873-7673 or 800-504-7357.