**Munson Healthcare Grayling Hospital**

# Miscellaneous

**PAYROLL DEDUCTION AUTHORIZATION**

I hereby authorize **Munson Healthcare entities** to deduct from my paycheck the amount listed below, payment for miscellaneous services. I also authorize the deduction of any amount owed to Munson Healthcare Grayling Hospital from my final paycheck/PTO payout in case of termination.

**EVENT: CRAF Center Membership**

**CHARGE ACCOUNT NUMBER: 58-3752-68200**

**Employee Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employee Number**:

# AMOUNT OWED: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER OF DEDUCTIONS (Max. 3)

# AMOUNT OF DEDUCTION: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

**RETURN THIS FORM TO PAYROLL**

Phone 231-935-6662 Fax 231-935-7659

**Munson Healthcare Grayling Hospital**

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