

Direct Deposit Authorization Form

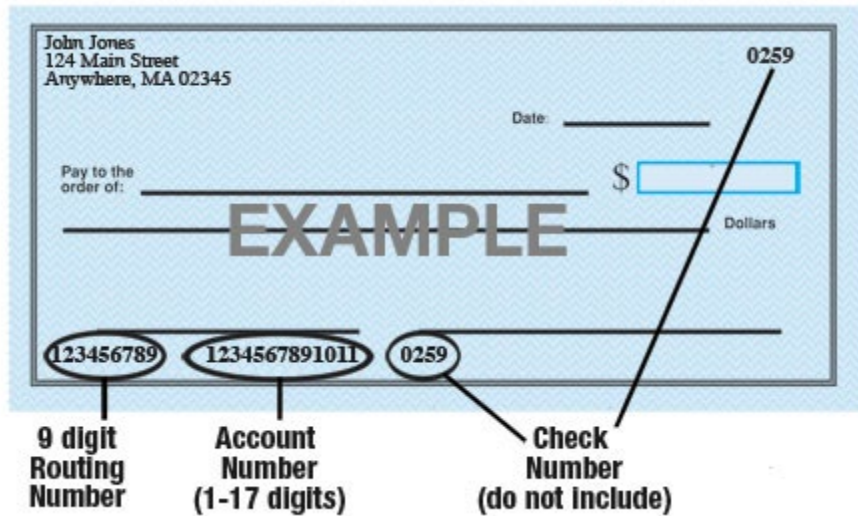
Please print and complete ALL of the information below.

Name: _____

Address: _____

City, State, Zip: _____

Email: _____



Please attach a voided check or deposit slip for the account to which funds should be deposited.

Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Type of Account: Checking Savings (Circle One)

HealthCare Resolutions is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____