



Authorization Agreement for Direct Deposit

- AUTHORIZATION
CANCELLATION

*please complete one for each account that you would like to set up or cancel for direct deposit.

I (we) hereby authorize Gifted Nurses/RMRG, hereinafter called COMPANY, to initiate credit entries to my (our)

- CHECKING
SAVINGS

Account(s) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account.

DEPOSITORY NAME:
CITY: STATE: ZIP:
ROUTING NO.: ACCOUNT NO.:

In the event of error, I authorize my bank/financial institution to initiate a reversal in the amount of the error to my account.

Direct Deposit timecards must be submitted by 1:00 pm daily or they will be processed the following day. Your funds will be available 48 business hours from the date of the processed time card.

This authority is to remain in full force and effect until COMPANY has received written notification from me (us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME:
(PLEASE PRINT)

SIGNED: DATE:

** Please attach a VOIDED CHECK **

Check form with fields for Name, Financial Institution, Pay to the Order of, Amount, Memo, Signature, and routing/account numbers.