



## Authorization for Direct Deposit

### Direct Deposit Authorization

Complete this form to enroll in direct deposit. Please remember to call The Nurse Agency if your account(s) changes, you close the account(s) or you no longer wish to receive Direct Deposit.

I hereby authorize the direct deposit of my payroll funds every pay period into the account(s) named below. I also authorize The Nurse Agency to withdraw any funds deposited to my account in error. I have attached a voided check or deposit slip for account verification:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Account #1

Name of Financial Institution: \_\_\_\_\_

Bank ABA Transit Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Account Type:    Checking: \_\_\_\_\_    Savings: \_\_\_\_\_

I wish to deposit: \$\_\_\_\_\_.\_\_\_\_ or \_\_\_\_\_ Entire Net Amount

### Account #2

Name of Financial Institution: \_\_\_\_\_

Bank ABA Transit Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Account Type:    Checking: \_\_\_\_\_    Savings: \_\_\_\_\_

I wish to deposit: \$\_\_\_\_\_.\_\_\_\_ or \_\_\_\_\_ Entire Net Amount