UR MEDICINE | ST. JAMES HOSPITAL

MEDICINE of THE HIGHEST ORDER

Direct Deposit Authorization Form

I hereby authorize St. James Hospital/ER Select to directly deposit my pay in the bank account(s) listed below in the percentages specified. (If two accounts are designated, deposits are to be made in whole percentages of pay to total 100%.) I have attached a voided personalized check (checking accounts) or deposit slip (savings accounts) for each account specified below. This authorization is to remain in force until the Company has received written authorization from me of its termination or change. Also, I hereby grant St. James Hospital the right to correct any such electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

Name (PRINT):_____

Signature: _____ Date: _____

Account #1 (Check only one)
[] Checking (attached voided check)
[] Savings (attach deposit slip and obtain ABA routing number from your bank)

Financial Institution: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: (_____) _____

Personal Account Number: _____

ABA (Routing) Number: _____

Amount of pay to be deposited into this account:
$_____ or _____%

Account #2 (Check only one)
[] Checking (attached voided check)
[] Savings (attach deposit slip and obtain ABA routing number from your bank)

Financial Institution: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: (_____) _____

Personal Account Number: _____

ABA (Routing) Number: _____

Amount of pay to be deposited into this account:
$_____ or _____%