Premier Healthcare Professionals

DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize Premier Healthcare Professionals to directly deposit payroll dollars earned through my employment into the account indicated below.

Account 1: Type **(circle one)** Checking or Savings

Account #_____ Routing ABA #_____

Depository Name/Branch: _____

City: _____ State: _____ Zip Code: _____

Amount (Full or Specified Amt.) $ _____

Account 2 (optional) Type **(circle one)** Checking or Savings

Account #_____ Routing ABA #_____

Depository Name/Branch: _____

City: _____ State: _____ Zip Code: _____

Amount (Full or Specified Amt.) $ _____

Authorization is to remain in effect until Premier Healthcare Professionals has received written notification of its termination in such time and in such manner as to afford Premier Healthcare Professional's reserves the right to deactivate a person's direct deposit upon notice of termination. The person's last 2 or 3 payroll checks may be live checks and will be mailed to the employee's last known address on file.

Full Name: _____

Signature: _____ Date: _____

Please attach a voided check from your bank account for verification purposes.

***Two "Accounts" are shown to allow you to split the destination of your funds (i.e. a portion can go directly into your savings account each pay day).*

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