DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize Children's Therapy Place to initiate automatic deposits to my account at the financial institution named below. I also authorize Children's Therapy Place to make withdrawals from this account in the event that a credit entry is made in error. This agreement will remain in effect until Children's Therapy Place receives a written notice of cancellation from me or my financial institution, or until I submit a new Direct Deposit form to the Payroll Department.

Employee Information and Authorization

Print Employee name as it appears on Payroll

Employee Signature

Date

Financial Institution Information

Name of Financial Institution

Address *(street, city, state, zip)*

Branch Location Name

Branch Location Phone

Branch Location Contact

CHECK ONE:

I am NOT currently participating in the Direct Deposit Program.

☐ *ADD* ----- *Please deposit my pay to the account shown below.**

I am currently receiving my pay through Direct Deposit.

☐ *CHANGE* ----- *Please change the financial institution and/or account number as shown below.**

☐ *CANCEL* ----- *Please stop my participation in the Direct Deposit Program.*

NOTE: Due to the time required for company and bank processing, please allow one or two pay periods for processing. You will receive a regular paycheck until the change has been processed.

Type of account *(check one):* ☐ **Checking Account** ☐ **Savings Account**

Authorized Signature Primary: _____ Date: ___ / ___ / 20___

Please staple a voided check or deposit slip to the back of this sheet and return this form to the Payroll Department.