COBB & DOUGLAS PUBLIC HEALTH

Direct Deposit Authorization

Please sign & return this form to the Payroll Department.

Authorization Agreement For Automatic Deposits

Name:	Employee ID:

New Enrollment ☐ **Change** ☐ **Stop Deposit** ☐

Please deposit my check directly into the following: (Attached is a copy of a voided check or a print out from my financial institution with the transit ABA (routing) number and account number).

		Checking ☐	**Savings** ☐
☐	Main Deposit Account	ABA#	ABA#
		ACCT#	ACCT#
OR			
☐	Partial Amount (indicate dollar amount)	ABA#	ABA#
		ACCT#	ACCT#
OR			
☐	Stop Direct Deposit	ABA#	ABA#
		ACCT#	ACCT#

Note: Your Entire Check Must Be Direct Deposited

I hereby authorize, **COBB & DOUGLAS PUBLIC HEALTH**, to credit my account for Direct Deposit of my payroll funds automatically each pay period and if necessary, to initiate debit entries or adjustment credits for payments made in error.

Terms:

This authority will remain in effect until I have canceled this direct deposit authorization in writing. This authority replaces any existing Direct Deposit(s) that I may currently have in place.

I understand it is my responsibility to always view my pay advice and verify that my payroll has been direct deposited and that the amount is correct.

Please note all direct deposit changes should be submitted at least 5 days in advance of the pay date

_____ _____

Employee Signature **Date**

FOR STAFF USE ONLY Date Entered:_____ Initials: _____