ASCENTIA HEALTHCARE LLC

Orientation Packet

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name: _____ **Employee SSN:** _____ - ____ - _____

I hereby authorize **ASCENTIA HEALTHCARE LLC** (Employer) to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account as follows:

	PRIMARY	SECONDARY
Bank Name:	_____	_____
Bank Phone #:	_____	_____
Bank Routing Number:	_____	_____
Branch Address:	_____	_____
	_____	_____
Name on Account:	_____	_____
Type of Account:	_____ (Checking or Savings)	_____ (Checking or Savings)
Account Number:	_____	_____
Indicate Specific Amount:	$_____	$_____
Or Indicate Percentage:	_____%	_____%

at the financial institution(s) as indicated. I further authorize the financial institution named in this authorization form to credit and/or debit such account(s).

I understand that this authorization remains in effect until the "Employer" receives from me, in writing, notification to terminate the authorization in such a time and a manner as to afford the "Employer" and my financial institution a reasonable time to act upon it. I acknowledge that I have been informed that it will take a reasonable amount of time (up to 15 business days) to complete the initial set up for my bank and particular account and that all paychecks prior to the full implementation will be delivered to me as fully negotiable paychecks.

_____ Employee/Account Holder Signature

_____ Joint Account Holder Signature (if required)

_____ Type or Print Name - CLEARLY

_____ Type or Print Name – CLEARLY

_____ Date Authorized

_____ Date Authorized

You must attach a voided check for processing to be completed