



AUTHORIZATION FOR DIRECT DEPOSIT-EMPLOYEE FORM

This authorizes Black River Medical Center to send credit entries electronically or by any other commercially accepted method, to my account(s) indicated below and to other accounts I (we) identify in the future. This authorizes the financial institution holding the Account to post all such entries.

Account #1

ACCOUNT TYPE	<input type="checkbox"/> Checking	or	<input type="checkbox"/> Savings
EMPLOYEE BANK NAME	_____		
BRANCH	_____		
CITY, STATE	_____		
ACCOUNT NUMBER	_____		
BANK ROUTING NUMBER	_____		

ACCOUNT #2

ACCOUNT TYPE	<input type="checkbox"/> Checking	or	<input type="checkbox"/> Savings
EMPLOYEE BANK NAME	_____		
BRANCH	_____		
CITY, STATE	_____		
ACCOUNT NUMBER	_____		
BANK ROUTING NUMBER	_____		

OTHER

ACCOUNT TYPE	_____
ACCOUNT NUMBER	_____
ROUTING NUMBER	_____

This authorization will be in effect until BRMC receives a written termination notice from myself and has a reasonable opportunity to act on it.

Signature: _____ DATE _____

Printed Name: _____ SS# _____

For Office Use Only: original employee file copy given to payroll department