Pushmataha Hospital

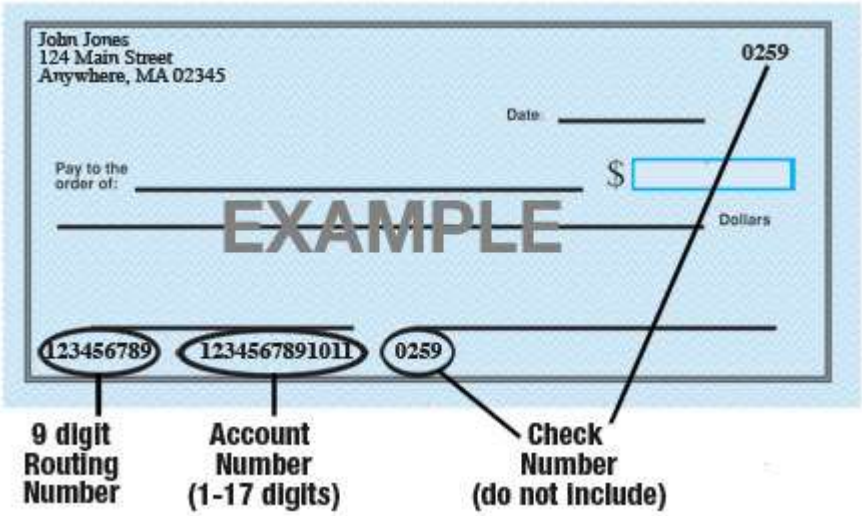
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ Entire Paycheck or ☐ $ _____ or ☐ _____%

Type of Account: Checking Savings Debit Card (Circle One)

Please attach a voided check/Bank Letter/website print out for each bank account to which funds should be deposited.

Pushmataha Hospital is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____