Authorization for Direct Deposit Form for Prominent Medical Staffing Inc.

INSTRUCTIONS: An authorization form must be completed for each direct deposit account. Complete each field on this form. Once completed fully, provide this form to your payroll administrator along with a copy of a voided check for the account, or a letter from the financial institution for confirmation of account information. Employees are responsible for notifying their financial institution of direct deposit from their employer.

1. **Employee Name:** ______________________________

2. **Employee Social Security Number:** ______________________________

3. **Employee Telephone Number:** ______________________________

4. **Action to be Taken – Check one**

   - ☐ Begin Direct Deposit
   - ☐ Stop Direct Deposit
   - ☐ Change Financial Institution
   - ☐ Change Account Number

5. **Name of Financial Institution:** ______________________________

6. **Bank Account Type – Check one**

   - ☐ Checking
   - ☐ Savings

7. **Bank Account Routing Number:** ______________________________
   (Routing Numbers are 9 digits and located on a check)

8. **Employee Account Number:** ______________________________

9. **Amount to be deposited each pay – Check one and complete fields**

   - ☐ Dollar Amount $______________
   - ☐ Percentage ________________ %

Unless otherwise indicated above, I hereby authorize and request Prominent Medical Staffing Inc. hereinafter referred to as EMPLOYER, to direct the amount or percent of my net pay for crediting to my account indicated at the Financial Institution designated above, and I further authorize the Financial Institution to credit the same to such account without responsibility for correctness of such amount.

This authorization will remain in effect until I have given written notice that I am terminating this contract, or until Employer has notified me that this deposit service has been discontinued. I understand that I must give advanced notice to allow reasonable time for my instruction to be executed. If an incorrect deposit should be made into my bank account, I authorize my bank and Employer to make the appropriate adjustment(s). Furthermore, I understand that termination of employment with my Employer shall constitute sufficient authorization to terminate this agreement.

I agree to notify my Employer if I wish to change the designated Financial Institution or account to which my direct deposit is made, 30 days prior to the effective date of such change. I understand that failure to do so may delay the receipt of my deposit.

10. **Signature of Employee** ______________________________ **Date** ______________