



Direct Deposit Employee
Authorization Form

This form gives United Cerebral Palsy and your financial institution authority to deposit your pay to your account. Please complete the information below and return to payroll.

I _____ authorize United Cerebral Palsy to initiate electronic credit entries each pay period, and if necessary, debit entries and adjustments for any credit entries in error to my:

_____ checking account (or) _____ savings account

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

FINANCIAL INSTITUTION NAME (PLEASE PRINT) _____

ACCOUNT NUMBER _____

ROUTING NUMBER _____

FINANCIAL INSTITUTION CITY AND STATE _____

Date _____

SIGNATURE _____

Please attach a voided check or deposit slip to this page