AUTHORIZATION FOR DIRECT DEPOSIT

NAME ______________________________

ADDRESS ______________________________

CITY ______________________________

STATE ________ ZIP ______________

PHONE ______________________________

☐ NEW
☐ CHANGE
☐ CANCEL

BANK NAME ______________________________

BANK ADDRESS ______________________________

BANK CITY ______________________________

BANK STATE ________ ZIP ______________

BANK ROUTING # ______________________________

ACCOUNT # ______________________________

TYPE OF ACCOUNT

☐ CHECKING
☐ SAVINGS

I herby authorize Children's Nutrition of Florida, Inc. to deposit any amounts owed to me by initiating credit entries to my account at the Financial Institution (herein referred as BANK) indicated above. Further, I authorize my BANK to accept and to credit any credit entries initiated by Children's Nutrition of FL, Inc. to my account. In the event that Children's Nutrition of FL, Inc. deposits funds erroneously into my account, I authorize Children's Nutrition of FL, Inc. to debit my account for an amount not to exceed the original amount of the credit. This authorization is to remain in full force and effect until Children's Nutrition of FL, Inc. has received written notice from me of its termination in such manner as to afford Children's Nutrition of FL, Inc. a reasonable opportunity to act on it.

______________________________ ______________
Provider Signature Date

STAPLE VOIDED CHECK OR DEPOSIT SLIP HERE