

NORTHERN HOSPITAL OF SURRY COUNTY
AUTHORIZATION FOR DIRECT DEPOSIT

Begin/Change/Add/Direct Deposit (Circle One)

Please forward form to the HR Department once completed.

I hereby authorize Northern Hospital of Surry County to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my

Checking Account (attach a voided check)

Checking/Savings Account (Routing # _____ Acct. # _____ Amt. \$ _____)

Checking/Savings Account (Routing # _____ Acct. # _____ Amt. \$ _____)

Checking/Savings Account (Routing # _____ Acct. # _____ Amt. \$ _____)

Checking/Savings Account (Routing # _____ Acct. # _____ Amt. \$ _____)

Bank Name _____ Address _____

City, ST Zip _____

This authorization is to remain in full force and effect for all payments made associated with my employment at Northern Hospital of Surry County.

PRINT YOUR
NAME _____ EMPLOYEE # _____

DATE _____ SIGNED _____