

# DOCS MED NOTES

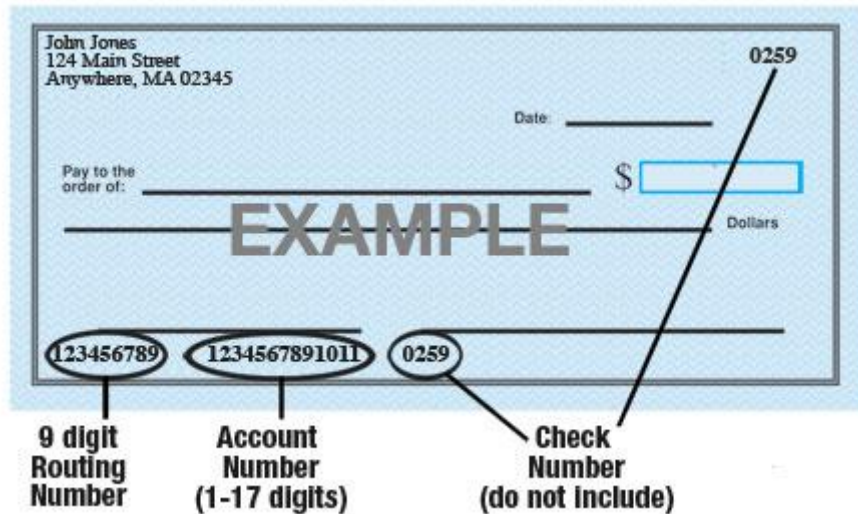
## Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_



Name of Bank: \_\_\_\_\_

Account #: \_\_\_\_\_

9-Digit Routing #: \_\_\_\_\_

Amount:  \$ \_\_\_\_\_  \_\_\_\_\_ % or  Entire Paycheck

Type of Account:    Checking    Savings(Circle One)

*Please attach a voided check for each bank account to which funds should be deposited.*

Docs Med Notes 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.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_