

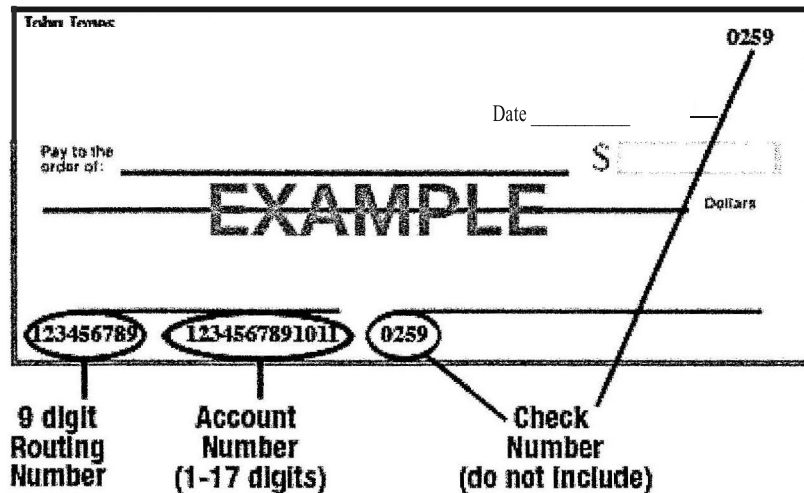
## Direct Deposit Authorization Form

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      (Check One)

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

**Healthcare Staffing Professionals, Inc.** 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.

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

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