

Direct Deposit Authorization Form

Please print and complete ALL the information below. Name: Address: _____ City, State, Zip: Techni Tempor 0259 Date ___ 1234567891011 123456789 9 digit Account Check Routing Number Number Number (1-17 digits) (do not include) Name of Bank: _____ Account #: _____ 9-Digit Routing #: _____% or Entire Paycheck Amount: 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:

6914 Canby Ave., Suite 109 Reseda, CA 91335 Office: (818) 936-3394 eFax: (818) 936-0158 Web: <u>www.hsp-inc.com</u>