Coastal Healthcare Resources, Inc.

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Coastal Healthcare Resources, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Coastal Healthcare Resources, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Coastal Healthcare Resources, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Coastal Healthcare Resources, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ ☐ Checking | ☐ Savings

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check and return this form to the Payroll Department.