DIRECT DEPOSIT AUTHORIZATION FORM

Please print and complete all information below.

Employee Name _____

Address _____

City, State, Zip _____

Direct Deposit Information

☐ Checking

Account # _____

Routing # _____

☐ Entire Net Pay

☐ Dollar Amount _____

☐ Savings

Account # _____

Routing # _____

☐ Entire Net Pay

☐ Dollar Amount

Delta Excellence Home Health Care, LLC 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's Signature: _____

Date: _____