RESET

Employer Use Only
Initial: _____
Date: _____

AUTHORIZATION FOR DIRECT PAY CHECK DEPOSITS

Western Maryland Health System
Effective Date: _____
(Please Print)

Check one box only
☐ Enrollment ☐ Cancel ☐ Change

Employee Name:	Social Security Number:
Department/Unit:	Payroll
Check: (PLEASE ATTACH A VOIDED DEPOSIT SLIP)	
☐ Checking Account #	☐ Savings Account #
Amount	Amount
$	$
Bank Route #	Bank Route #
Bank Name	Bank Name

I hereby authorize Western Maryland Health System (WMHS) to deposit my net salary to credit same to the checking and/or savings account described above. This authorization is to remain in force until WMHS has received written notification from me of its termination in such time and in such manner as to afford WMHS and/or the Bank a reasonable opportunity to act on it.

In the event that the WMHS notified the Bank that funds to which I am not entitled have been deposited to my account inadvertently, I hereby authorize and direct the Bank to return said funds to the WMHS as soon as possible.

Signature _____ Date _____