THE UNIVERSITY OF VERMONT MEDICAL CENTER
Direct Deposit Authorization

Name _____ Employee ID _____
(please print)

I authorize The University of Vermont Medical Center and the financial institution listed below to automatically deposit entries and to make corrective adjustments in the event of an overpayment to my account.

Signature _____ Date _____

ATTACH VOIDED CHECK FOR EACH CHECKING ACCOUNT

1. Deposit Net Pay to the following:

Bank Name: _____ Bank Transit/ABA no. _____

Account No. _____ Amount/percent _____ Checking____ Savings ____

ATTACH A VOIDED CHECK FOR ACCOUNT VERIFICATION

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2. Deposit fixed amount or percentage of net pay to the following:

Bank Name: _____ Bank Transit/ABA no. _____

Account No. _____ Amount/percent _____ Checking____ Savings ____

ATTACH A VOIDED CHECK FOR ACCOUNT VERIFICATION

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3. Deposit fixed amount or percentage of net pay to the following:

Bank Name: _____ Bank Transit/ABA no. _____

Account No. _____ Amount/percent _____ Checking____ Savings ____

ATTACH A VOIDED CHECK FOR ACCOUNT VERIFICATION

Your direct deposit will take effect on the **First** Pay period after your request is received. This form must be received in Payroll no later than the Thursday prior to the pay date on which you would like this form to take effect.

TO CHANGE YOUR DIRECT DEPOSIT, SUBMIT A NEW FORM.

SEND THIS FORM TO THE: PAYROLL OFFICE, St. Joseph, 1 South Prospect Street Mail Stop: 413OH5
Phone: 847-3760 Fax: 847-4809 e-mail: payroll@uvmhealth.org