



ELECTRONIC PAYMENT AUTHORIZATION

I hereby authorize Elohim Medical Staffing Agency, Inc to initiate deposits for payroll or to initiate withdrawals for self-cancellation or no show fees as payment of services to the account and the financial institution named below. I also authorize a reversal a reversal for credit/debit errors.

Checking Account Savings Account

A \$30.00 returned check fee will be assessed on any payments returned due to insufficient funds. To the best of my knowledge, information provided on this agreement is true and accurate and I have the authority to bind the above actions on this account. This authorization will remain in full force unless cancelled by me in writing.

Signature: ----- Date:/...../20.....
Printed Name: -----

ELECTRONIC PAYMENT AUTHORIZATION

Routing Number: _____

Account Number: _____

Financial institution Name: _____

Address: _____

Please attach a copy of voided check or written bank Documentation here.