(Please attach a voided check)

NORTH MEMORIAL AMBULATORY SURGERY CENTER AT MAPLE GROVE (NMASCMG)

Direct Deposit Authorization Form

I authorize NMASCMG to initiate credit entries, and if needed debit entries to adjust previous credit entries in error to either my:

_______ Checking Account for __________% or $ __________
(Please attach a voided check)

____
Name of Financial Institution

________________ ____________ ____________
City State Zip

________________ ________________________
Transit/Routing Number Account Number

AND/OR MY:

_______ Savings Account for __________% or $ __________
(Please attach a voided deposit slip)

____
Name of Financial Institution

________________ ____________ ____________
City State Zip

________________ ________________________
Transit/Routing Number Account Number

This authorization is effective from the time of signature through the time NMASCMG receive written notification of change or discontinuance. The above time stated should offer NMASCMG and the respective financial institution reasonable time to act.

_________________________ __________________________
Employee Name (please print) Social Security Number

____
Address

____
City State Zip Code

_________________________ __________________
Signature Date