



**PAYROLL INFORMATION**

Employee Name: \_\_\_\_\_  
First Middle Initial Last

Employee Address: \_\_\_\_\_  
Address Street Name  
\_\_\_\_\_  
City State Zip

Social Security #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_

**DIRECT DEPOSIT INFORMATION**

**(Fill out the information below and /or attach a voided check)**

NAME OF BANK (OR FINANCIAL INSTITUTION): \_\_\_\_\_

CITY AND STATE OF BANK (OR FINANCIAL INSTITUTION): \_\_\_\_\_  
City State

ROUTING NUMBER: \_\_\_\_\_ ACCOUNT NUMBER: \_\_\_\_\_

I HEREBY AUTHORIZE MY EMPLOYER, SKIPSTONE HEALTHCARE STAFFING, TO DEPOSIT ANY AMOUNTS OWED ME BY INITIATING CREDIT ENTRIES TO MY ACCOUNTS AT THE FINANCIAL INSTITUTIONS (herein after "Bank") INDICATED ON THIS FORM. FURTHER, I AUTHORIZE THE ABOVE LISTED BANK TO ACCEPT AND TO CREDIT ANY CREDIT ENTRIES INDICATED BY SKIPSTONE HEALTHCARE STAFFING, COMPANY, TO MY ACCOUNTS. IN THE EVENT THAT THE PAYROLL COMPANY DEPOSITS FUNDS ERRONEOUSLY INTO MY ACCOUNT, I AUTHORIZE COMPANY TO DEBIT MY ACCOUNT FOR AN AMOUNT NOT TO EXCEED THE ORIGINAL AMOUNT OF THE ERRONEOUS CREDIT. THE AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL COMPANY AND BANK HAVE RECEIVED NOTICE FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD COMPANY AND BANK REASONABLE OPPORTUNITY TO ACT ON IT.

X \_\_\_\_\_  
EMPLOYEE SIGNATURE DATE

X \_\_\_\_\_  
EMPLOYEE PRINTED NAME