Northeast Ohio Medical University

Direct Deposit Authorization Agreement

_____ New Authorization **_____ Change in existing authorization**

STUDENT INFORMATION

Legal Name (Last, First, Middle Initial) _____ Student ID Number (if applicable) _____

Current Address: _____ (*Street*) _____ *(City)*

_____ *(State)* _____ *(Zip Code)*

Telephone Number _____ email address _____

I hereby authorize Northeast Ohio Medical University and the DEPOSITORY named below, to initiate direct deposit entries and to initiate, if necessary, reversal entries to adjust for any deposit entries made in error to my account also indicated below.

This authorization is to remain in full force and effective until NEOMED has received written notification from me of its termination, or in such time and in such manner as to afford NEOMED and DEPOSITORY a reasonable opportunity to act on it. I further understand NEOMED maintains the right to terminate, suspend or amend the Direct Deposit program in whole or in part at any time.

When signing up for this method of receiving monies, I will notify NEOMED of any changes in my designated account in a timely fashion.

Student's Signature _____ Date _____

DEPOSITORY INFORMATION

Please attach one of the following that identifies the account number and the depository institution transit routing number:

_____ Voided Check **_____ Copy of savings account card**

Name of Financial Institution _____ Institution Transit Routing Number _____

Branch _____ Institution Account Number _____

City, State, Zip _____ Type of Account: ____ Checking ____ Savings

Return completed form and supporting attachment(s) to the NEOMED Accounting & Purchasing Department or mail to:

NEOMED
Accounting & Purchasing Department
4209 St. Rt. 44
Rootstown, OH 44272

Direct deposit confirmations will be made to your email account.