DIRECT DEPOSIT AGREEMENT

Authorization Agreement

I hereby authorize **FOCUS CARE, Inc** to initiate automatic deposits to my account at the financial institution named below. I also authorize **FOCUS CARE, Inc** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **FOCUS CARE, Inc** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **FOCUS CARE, Inc** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

_______________________________________ ____

Employee name (please print) Employee signature date

Account Information

□ **CHECKING** □ **SAVINGS** □ net pay □ fixed amt _________	□ **CHECKING** □ **SAVINGS** □ net pay □ fixed amt _________	□ **CHECKING** □ **SAVINGS** □ net pay □ fixed amt _________	□ **CHECKING** □ **SAVINGS** □ net pay □ fixed amt _________
____________________ name of financial institution	____________________ name of financial institution	____________________ name of financial institution	____________________ name of financial institution
____________________ routing number	____________________ routing number	____________________ routing number	____________________ routing number
____________________ account number	____________________ account number	____________________ account number	____________________ account number

Please attach a deposit slip for each account and return this form to the Payroll Department.