EMPLOYEE DIRECT DEPOSIT AUTHORIZATION AGREEMENT

CLIENT #:ZZT (MUST HAVE YOUR 4 DIGIT CLIENT NUMBER)

_____ New Payroll Deposit _____ Change Deposit Information _____ Revoke Authorization

I hereby authorize my employer, _MED STAFF, INC._____, (Hereinafter COMPANY) and its payroll processor, ADP© to deposit any amounts owed me by initiations credit entries to my account at the financial institution (Hereinafter BANK) indicated below. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY or ADP to my account. In the event that COMPANY or ADP deposits funds erroneously into my account, I authorize COMPANY or ADP to debit my account for an amount not to exceed the original amount of the erroneous credit.

Employee Signature X_____ Date _____

Employee Name (Print) X_____ SS# _____

Employee Number X_____

Complete Section 1 OR Section 2

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SECTION 1: CHECKING ACCOUNT: (Attach A Void Check)

Bank Name _____ City _____ State _____

_____ Entire Net Pay

ATTACH A VOID CHECK HERE

The numbers on the bottom of the voided check are used
to make the electronic funds transfer directly to your account.

PLEASE NOTE THAT ELIGIBILTY FOR DIRECT DEPOSIT WILL OCCUR 10 WORKING DAYS AFTER THE WEDNESDAY OF RECEIPT

-OR-

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SECTION 2: SAVINGS ACCOUNT: Call Your Bank To Obtain The Following Information:

Bank Name _____ City _____ State _____

_____ Entire Net Pay $_____ specific dollar amount

(Please Complete The Following)

BANK ROUTING & TRANSIT # ___ ___ ___ ___ ___ ___ ___ ___ ___ (MUST BE 9 DIGITS)

EMPLOYEE'S SAVINGS ACCOUNT #

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