DIRECT DEPOSIT AUTHORIZATION

Please check one of the following: ____ NEW ____ CHANGE ____ TERMINATE

***IMPORTANT: FOR EACH ACCOUNT BELOW, PLEASE ATTACH A VOIDED CHECK. ALLOW UP TO 10 BUSINESS DAYS FOR DEPOSIT TO BECOME EFFECTIVE.**

I hereby authorize ELITE NURSING SERVICES INC. to initiate credit entries and if necessary, debit entries to reverse erroneous credit entries to my account(s) below:

Employee: _____

Social Security No: _____

Bank Name and Branch: _____

Your Bank Account No.: _____ [ ] Checking [ ] Savings

Bank ABA/Routing Number: _____

Amount to be deposited: _____ Fixed Amount of $ (please specify amount)

_____ Remaining Net Pay (after deposit of fixed amount)

_____ Full Net Pay

_____ _____

Employee Signature Date

Please attach a copy of voided check for verification.