



AUTHORIZATION FOR DIRECT DEPOSIT

NAME _____
 ADDRESS _____
 CITY _____
 STATE _____ ZIP _____
 PHONE _____

NEW
 CHANGE
 CANCEL

BANK NAME _____
 BANK ADDRESS _____
 BANK CITY _____
 BANK STATE _____ ZIP _____
 BANK ROUTING # _____
 ACCOUNT # _____

TYPE OF ACCOUNT

CHECKING
 SAVINGS

I hereby authorize Children's Nutrition of Florida, Inc. to deposit any amounts owed to me by initiating credit entries to my account at the Financial Institution (herein referred as BANK) indicated above. Further, I authorize my BANK to accept and to credit any credit entries initiated by Children's Nutrition of FL, Inc. to my account. In the event that Children's Nutrition of FL, Inc. deposits funds erroneously into my account, I authorize Children's Nutrition of FL, Inc. to debit my account for an amount not to exceed the original amount of the credit. This authorization is to remain in full force and effect until Children's Nutrition of FL, Inc. has received written notice from me of its termination in such manner as to afford Children's Nutrition of FL, Inc. a reasonable opportunity to act on it.

Provider Signature _____

Date _____

STAPLE VOIDED CHECK OR DEPOSIT SLIP HERE