WEST CARROLL HEALTH SYSTEM

DIRECT DEPOSIT AUTHORIZATION — One Account

I (we) hereby authorize West Carroll Health Systems, hereinafter called "COMPANY", to initiate credit entries and, if necessary, debit correction and adjustment entries to my (our) account at the financial institution listed below, hereinafter called DEPOSITORY. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. laws and regulations.

Depository Name _____ Branch _____

Address _____ City _____ State _____ Zip _____

Routing & Transit Number _____ Account Number _____

Account Type: □ Checking/Draft

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such a time and manner as to afford COMPANY and DEPOSITORY a reasonable time to act upon it.

Name(s) _____ SS Number _____
(Please Print)

Date _____ Signature(s) _____

Please attach a voided check or financial institution account verification letter to this form. Check or verification letter must have your name preprinted on form.

Note: Written credit authorization must provide that the receiver may revoke the authorization only by notifying the orginator in the manner specified in the authorization.

Direct Deposit