

Supplemental Health Care SM

STAFFING SPECIALISTS

2005 SHERIDAN DRIVE • BUFFALO • NEW YORK • 14223 • WWW.TRAVELNURSES.COM
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AUTHORIZATION AGREEMENT for Automated Clearing House Entries (Debit/Credit)

I (we) hereby authorize SUPPLEMENTAL HEALTH CARE, hereinafter called COMPANY, to initiate debit/credit entries to my (our) () Checking Account() Savings Account (select one) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit/credit the same such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depositor Name: _____ Branch: _____
City: _____ State: _____ Zip: _____
Routing Number: _____ Account Number: _____

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 time and manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name: _____ Social Security Number: _____
Signature: _____ Date: _____

Name 2 (if required): _____ Social Security Number: _____
Signature 2 (if required): _____ Date: _____

Please attach an original voided check.

VOID