

## EMPLOYEE DIRECT DEPOSIT AUTHORIZATION AGREEMENT

EMPLOYEE NAME		SOCIAL SECURITY NUMBER	
POSITION HELD		DAYTIME PHONE	
STREET ADDRESS			
CITY		STATE	ZIP CODE

NAME OF FINANCIAL INSTITUTE			
BANK ADDRESS			
CITY		STATE	ZIP CODE
TRANSIT ROUTING NUMBER	<input type="radio"/> CHECKING <input type="radio"/> SAVINGS	ACCOUNT NUMBER	

I Hereby Authorize MEDSOURCE to initiate electronic credit entries, and if necessary, debit entries and adjustments for any credit entries in error to my account listed above. Furthermore, I authorize the Bank named above to credit and debit the same entries to such account. This authorization shall remain in full force and effect until MEDSOURCE has received written notification from me on its termination in such time and in such manner as to afford MEDSOURCE a reasonable time to act upon it.

APPLICANT SIGNATURE	DATE
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STAPLE VOIDED CHECK HERE  
COPIES ARE NOT ACCEPTABLE

Be Sure To Allow At Least Two Complete Payroll Periods For Direct  
Deposit Request To Be Processed

Call (800) 440-1909 If You Have Any Questions.

PLEASE COMPLETE AND RETURN TO THE FOLLOWING ADDRESS:

NATIONAL OFFICE • 33 NORTH GARDEN AVENUE • SUITE 800 • CLEARWATER, FL 33755 OR  
WESTERN DIVISION • 3838 MEDICAL DRIVE • SUITE 206 • SAN ANTONIO, TX 78229

WWW.MEDSOURCETRAVELERS.COM