

DIRECT PAYROLL DEPOSIT AUTHORIZATION

Note: Must return with original signature. Do not fax or return copies.

I authorize the Johns Hopkins Hospital and bank listed below to deposit my net pay automatically to my account each payday. If funds to which I am not entitled are deposited to my account, I authorize you to direct the bank to return the said funds. The authority will remain in effect until I have cancelled it in writing.

DATE: ____/____/____

SOCIAL SECURITY #: ____-____-____

HOSPITAL

BAYVIEW

HEALTH SYSTEM

NAME: _____

CHECKING ACCOUNT

SAVINGS ACCOUNT

NAME OF BANK: Johns Hopkins FCU

TRANSIT NUMBER: 252076235

BANK ACCOUNT NUMBER: _____

SIGNATURE: _____

*If you are applying the direct deposit to a Credit Union, please contact them to verify the Transit Number before submitting this form.