VCU Health System
Virginia Commonwealth University
MCV Hospitals and Physicians

DIRECT DEPOSIT AUTHORIZATION

HOSPITAL ________________________________
PHYSICIANS ______________________________
HOUSE STAFF______________________________
CHILDREN HOSPITAL _______________________

(Please Print)
NAME: ______________________________ SOCIAL SECURITY #__________________
DEPARTMENT: __________________OFFICE PHONE: _________ HOME PHONE: ____________

I authorize VCU Health Systems (VCUHS) to credit or adjust automatically to the account(s) listed below, all net pay amounts payable to me by VCUHS. If funds to which I am not entitled are deposited into my account, I authorize VCUHS to direct the financial institutions involved to return said funds. This authority is to remain in effect until VCUHS has received written notification from me of its termination in such time and in such manner as to afford VCUHS a reasonable opportunity to act upon my request.

I understand that I may have a maximum of **four (4) accounts** set up for direct deposit at one time.

I understand that a voided check or deposit slip is required in order to process this deposit authorization.

I understand that direct deposit should become effective the second pay period after the completed authorization form is received by VCUHS Payroll.

In the event that I am in a *dock* status for two (2) successive pay periods**,** VCUHS *may cancel my DIRECT DEPOSIT AUTHORIZATION* and paychecks will be the method of payment.

- ☐ New Account
- ☐ Add another account for Direct Deposit.
- ☐ Change in financial institution.
- ☐ Change in account number at the same financial institution.
- ☐ Change of amount in an existing account**.**
- ☐ Cancel my current DIRECT DEPOSIT AUTHORIZATION.

BANK NAME: ______________________________________CHECKING_☐__ SAVINGS_☐_
ROUTING NUMBER ___________________________ACCOUNT NUMBER: __________________
AMOUNT PER PAY PERIOD: _________

BANK NAME: ______________________________________CHECKING_☐__ SAVINGS_☐_
ROUTING NUMBER ___________________________ACCOUNT NUMBER: __________________
AMOUNT PER PAY PERIOD: _________

BANK NAME: ______________________________________CHECKING_☐__ SAVINGS_☐_
ROUTING NUMBER ___________________________ACCOUNT NUMBER: __________________
AMOUNT PER PAY PERIOD: _________

BANK NAME: ______________________________________CHECKING_☐__ SAVINGS_☐_
ROUTING NUMBER ___________________________ACCOUNT NUMBER: __________________
AMOUNT PER PAY PERIOD: _________

PLEASE SIGN HERE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THIS AUTHORIZATION.
SIGNATURE ________________________________ DATE __________________

Return to VCUHS **Campus Box** 980132 **Fax: 828-5244**
Please call Joan James at 828-6764, if you have any questions

Revised 3/9/2011