Attachment 1

LSU HEALTH SYSTEM
HEALTH CARE SERVICES DIVISION

WWW.LSUHOSPITALS.ORG

Direct Deposit Authorization Form

Select One: New ☐ Add ☐ Replace ☐

Employee Name:_____

Address as appears on Account _____

Home Department: _____ Work #:_____

Complete a separate form for each financial institution

Financial Institution (Bank Name)_____

City:_____ State:_____ Zip:_____

Bank Routing Number :_____(Nine Digit Number at Bottom/Left of Check, if Credit Union or Savings account must obtain the correct Bank transit number from financial Institute)

One account must be indicated as Net or Balance.

Checking Acct #: _____ Amount to Deposit: _____or Net☐

Savings Acct #:_____ Amount to Deposit: _____or Net☐

Credit Union #:_____ Amount to Deposit: _____or Net☐

IMPORTANT

Please attach a voided, photocopied, or cancelled check (for checking account) or deposit slip (for savings account only) here so that we can obtain an accurate routing and transit number for the financial institution designated to receive your deposit. (Some checking account deposit slips do not include routing and transit numbers.)

I hereby authorize the HCSD to initiate credit entries or if necessary debit entries and adjustments for any credit entry made in error to my account at the indicated financial institution, and I hereby authorize the indicated institution to accept and post such entries to my account.

This authorization may be terminated by Heath Care Services Division at any time.

Employee Signature Date _____Date_____

Allow one to two pay periods for direct deposit*

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For office use only Empl Id_____ Date Entered into PS_____