



STUDENT Authorization Agreement for Automatic Payroll Deposits

Company: **Auxiliary Services**

Student Employee Name: _____ Telephone No.: _____

Work Location(s): _____ Email Address: _____

I (we) hereby authorize Auxiliary Services, and the **Financial Institution** named below, to initiate deposits (ACH credit entries) to my (our) **Account** (hereinafter called **Account**.) I (we) also authorize Auxiliary Services and the **Financial Institution** to initiate, if necessary, any debit entries and adjustments for any credit entries made in error to my (our) **Account**.

Financial Institution: _____

City: _____ State: _____ Zip: _____

Transit/ABA # (9 digits) _____ (If checking, the number is located on the bottom, far left of the check/deposit slip.)

Account # (up to 17 characters) _____

Please note: Debit cards do not have the correct account number. Information for this form should come from your check/deposit slip (with your name pre-printed on it, NO STARTER checks) or Financial Institution representative.

- Account Type:** **Checking Account** (Attach a voided check or deposit slip (must be pre-printed with your name), or have your Financial Institution representative complete both the ABA/Account # sections and the box below.)
- Savings Account** (Have your Financial Institution representative complete both the ABA/Account # sections and the box below.)

If you do not have checks or a pre-printed deposit slip to your account, please have your financial institution representative complete the Transit/ABA and Account information sections, and complete the areas below:	
_____	_____
Financial Institution Representative (print name)	Office Location & Contact Phone
_____	_____
Financial Institution Representative (signature)	Date

I (we) give authorization to deposit (credit) 100% of net pay (my entire check) to this **Account**.

This authorization is to remain in full force and effect until Auxiliary Services has received written notification from me (or either of us) to terminate it. Upon receipt of notification to terminate this authorization, Auxiliary Services and the **Financial Institution** shall have reasonable time and opportunity to act on it.

Account Holder(s) (please print): _____

Signatures of Account Holder(s): _____

Date: _____

STUDENT MUST RETURN THIS FORM IN PERSON TO ROOM 506 CULKIN HALL

If you have any questions, please call the Accounting Office at (315)312-3669, or email staspay@oswego.edu.