AUTHORIZATION FOR
AUTOMATIC (DIRECT) DEPOSIT

Wapiti Medical Group

I/We authorize the COMPANY (named above) to initiate credit entries and, if necessary, to initiate any debit entries to correct an erroneous credit entry to my/our account at the DEPOSITORY (identified below), for the purpose of automatically depositing funds to my/our account. I/We acknowledge that the origination of these transactions must comply with the provision of U.S. law.

DEPOSITORY NAME:_____

BRANCH:_____ PHONE:_____

CITY:_____STATE:_____ZIP:_____

ROUTING NUMBER:_____
***(see attached voided check/draft or deposit slip)**

ACCOUNT NUMBER:_____

(check one) _____**Checking** _____**Savings**

_____**New Authorization** _____**Change** _____**Termination**

I/We understand that this authorization replaces any previous authorization and will remain in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it.

NAME(S) - Printed:_____

_____ _____

(signature) **(date)** **(signature)** **(date)**

I decline from the AUTOMATIC (DIRECT) DEPOSIT option.

_____

(signature) **(date)**