

DIRECT DEPOSIT ENROLLMENT FORM

* Please complete your W9 form and Direct Deposit form and return to officemanager@competentmedicalsolutions.com

Employee Name _____

Address _____

City _____ State _____ Zip Code _____

BANK INFORMATION

Checking Account Number _____

Routing Number _____

I authorize Competent Medical Solutions and my bank to automatically deposit my payroll check into my account listed above. This authorization will remain in effect until I give written notice to cancel it.

Customer Signature _____

Date _____