Student Direct Deposit Authorization Form

Class of _____

PLEASE PRINT:

Student SSN (Last four Digits) _____ **Date:** _____

Student Name: _____ _____ _____
Last **First** **M.I.**

Address: _____

Phone: _____ **Email:** _____

Authorization Agreement for Direct Deposit Payments

By signing this form, I agree to the following terms and authorize my refunds to be deposited directly to my U.S. checking account at the financial institution shown below:

- This authority will remain in effect until I file a new authorization form or make a written request to cancel my participation.
- It is my responsibility to notify the Student Accounts Office of any changes or closed accounts at least 7 business days prior to my next payment.
- If funds to which I am not entitled are deposited to my account, I authorize the Alabama College of Osteopathic Medicine to direct my financial institution to return said funds.

_____

Student Signature Date

Attach Your Check Here

(**Starter checks and deposit slips may not be used**)

Write **VOID** across the check

- The check must be from your personal checking account at a U.S. financial institution.
- Joint accounts are acceptable if your name appears on the check.
- An authorized direct deposit form from your financial institution may be used in place of a voided check.

Complete the Student Direct Deposit Form and return to the Alabama College of Osteopathic Medicine, Att: Bursar's Office – Pam Deal, 445 Health Sciences Boulevard, Dothan AL 36303.