

AUTHORIZATION AGREEMENT FOR AUTOMATED DEPOSITS (CREDITS)

Employee Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

I hereby authorize REGIONAL SCHOOL DISTRICT ONE AND SALISBURY BANK AND TRUST COMPANY, hereinafter called *Entities*, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for credit entries in error to my () checking () savings account (*select one*) indicated below and Depository named below, hereafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY

Name: _____

City: _____ **State:** _____ **Zip:** _____

Routing No.: _____

(9 digit no. starting with "0" or "2", can be found on your check or deposit slip or obtained from your bank)

Account No.: _____

These authorities are to remain in full force until ENTITIES have received written notification from me of its termination in such time and in such manner as to afford ENTITIES and DEPOSITORY a reasonable opportunity to act on it.

Name: _____

Signature: _____ **Date:** _____

Please attach a voided check if checking account is selected.

Send completed authorization form and sample "Voided Check" to: Mrs. Christine Olownia – Region One School District – 246 Warren Turnpike Road – Falls Village, CT 06031. Call 860.824.5123 x.309 with any questions.

FOR ENTITIES USE ONLY

Date Received: _____

Processed By: _____

Follow Up Action Required: _____
