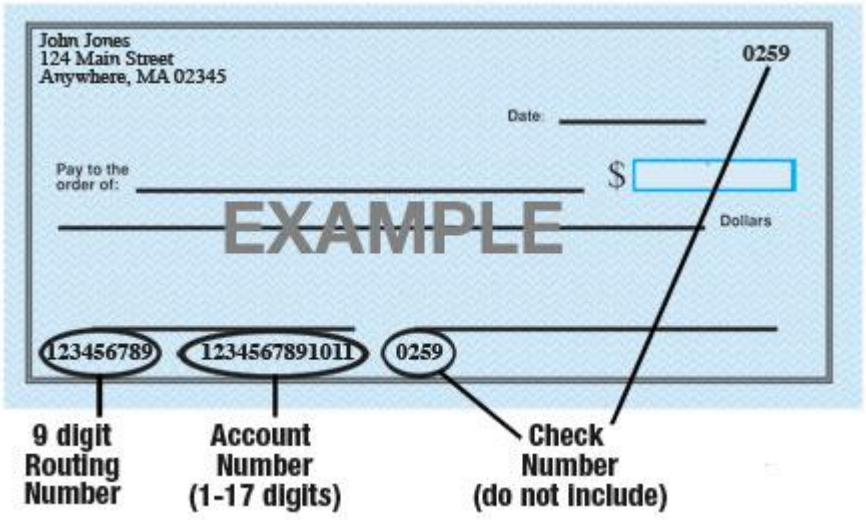
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

Re Enter Account #: _____

9-Digit Routing #: _____

Type of Account: Checking Savings (Circle One)

Vision Home Health Care is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Authorized Person name:_____

Date:_____