

AUTHORIZATION FOR DIRECT DEPOSIT

Complete this form for each individual electing direct deposit.

I authorize American College of Apothecaries, Inc. to deposit my compensation automatically to the account(s) indicated below and, if necessary, to adjust or reverse a deposit for any payment made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford American College of Apothecaries, Inc. a reasonable opportunity to act on it.

Primary Direct Deposit

Name on bank account: _____

Bank account number: _____ Checking ___ Savings ___

Bank routing number: _____

Important: Please attach a voided check or check image for the bank account to which funds should be deposited.

Signature: _____

Date: _____