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| --- | --- | --- | --- | --- |
| ***KGH Use Only*** |  |  | **Vendor Account Number:** | K |

**EFT Authorization Form**

|  |  |
| --- | --- |
| **Company Name:** |  |
| **Address:** |  |
|  |  |
| *Please check one to indicate preference for remittance advice:* |
| **Fax number:**  |  |  |  |
| ***or*** |  |
| **Email address:** |  |  |  |

|  |  |
| --- | --- |
| **Remittance Contact Name:** |  |
| **Title:** |  |
| **Phone number:** |  |
| **Email:** |  |

|  |  |  |
| --- | --- | --- |
| **Branch Transit** | **Institution #** | **Account Number** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Bank Name:** |  |
| **Branch** |  |
| **Branch Address** |  |
| **City / Province:** |  | **Postal Code** |  |
| **Contact at Bank:** |  | **Phone** |  |

*I certify that the information above is true and correct and that I, as an authorized representative for the above named company, hereby authorize Kingston General Hospital to electronically deposit payments to the designated bank account.*

|  |  |
| --- | --- |
| **Date:** |  |
| **Authorized Signature:** |  |
| **Print name / Title:** |  |
| **Phone:** |  | **Email:** |  |
| **Date:** |  |
| **Authorized Signature:** |  |
| **Print name / Title:** |  |
| **Phone:** |  | **Email:** |  |

Completed form to be sent by:

E-mail to: kghmm.accpay@kgh.kari.net OR

Faxed to: 613-548-6112