AUTHORIZATION FOR DIRECT DEPOSIT
Please complete and return to:
admin@cprinc.biz
or fax to **866-815-7277**

This authorizes **CPR Anesthesia, Inc.** (the "Company"), to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Account #1
Account #1 Type (check one): ☐ Checking ☐ Savings

Name of account holder:			
Provider Bank Name:			
Bank Routing # (ABA#):		Account #	
Percentage or Dollar Amount to be Deposited to this Account:			

(The routing number is the first nine numbers on the bottom left portion of your personal check)

Account #2 (Remainder to be deposited to this account)
Account #2 Type (check one): ☐ Checking ☐ Savings

Name of account holder:			
Provider Bank Name:			
Bank Routing # (ABA#):		Account #	
Percentage or Dollar Amount to be Deposited to this Account:			

Please attach a voided check for each account here.

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Signature / Date

Printed Name / Date

IMPORTANT: This document must be signed by providers requesting automatic deposit of payment and retained on file by CPR Anesthesia, Inc. Providers must attach a voided check for each of their accounts in order to verify their account and bank routing numbers, failure to do so may delay payment.