



## LSU Health Foundation, New Orleans

### ACH / Direct Deposit Vendor Authorization Agreement Form

#### Authorization Agreement

I hereby authorize LSU Health Foundation, New Orleans to initiate automatic deposits to my account at the financial institution named below for Automated Clearing House (ACH) payments and direct deposit reimbursements. I also authorize LSU Health Foundation, New Orleans to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold LSU Health Foundation, New Orleans responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until LSU Health Foundation, New Orleans receives a written notice of cancellation from me or my financial institution, or until I submit a new form to the Foundation Finance Department by contacting Laurie Phillips at [lphillips@lsuhealthfoundation.org](mailto:lphillips@lsuhealthfoundation.org).

#### Account Information

Account Type:  Checking  Savings

Name on Acct \_\_\_\_\_

Bank Name \_\_\_\_\_

Account Number \_\_\_\_\_

Bank Routing # \_\_\_\_\_

Bank City/State \_\_\_\_\_



#### Signature

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_