BANK ACH AUTHORIZATION

Supporter hereby authorizes **Choices Clinic of Laurel** to withdraw the amount for monthly support by initiating debit entries to Supporter's account at the financial institution (hereinafter "Bank") indicated in this agreement. These debits will be sent no later than the **20th of each month** during which support is given. Such authorization may be cancelled by the Supporter at any time, in writing, at least 14 days before the draft date of the month in which you wish to stop.

Bank Name:	Bank Phone Number (optional):
Bank Account Number (not to exceed 17 digits):	Type of Account: ☐ Savings ☐ Checking
Bank Routing and Transit Number (required 9 digits):	Requested Effective Date (optional):
Print Name:	Phone Number:
Authorized Signature:	Date Signed:
Reason for Payment: **MONTHLY SUPPORT**	Amount:
Frequency of Payment: **MONTHLY**	

ATTACH VOIDED CHECK HERE

A voided check from your checking account must be included in this application
(Do not use a deposit ticket or temporary check)