HEALTH CARE
INNOVATIONS
Leaders in Nursing Excellence

Payroll Distribution Authorization

Employee Name:_____ Date:_____

Social Security Number: _____ Phone:_____

I authorize Health Care ***INNOVATIONS*** to take the following action with my net salary:

Check One:

☐ 1. Issue a payroll check and mail to my address on file.

☐ 2. Deposit directly to my account(s) listed below. A pay stub remittance will be mailed.
(May take two pay periods to allow for pre-note process)

☐ 3. Change bank and/or account to which my net salary is deposited.
(You will receive a payroll check until new account is established) DO NOT CLOSE ACCOUNT UNTIL PAYROLL CHECK IS ISSUED.

☐ 4. Discontinue direct deposit and issue a payroll check instead.
DO NOT CLOSE ACCOUNT UNTIL PAYROLL CHECK IS ISSUED.

Direct Deposit Application (For accuracy, we recommend attaching a voided check)

Financial Institution: _____ Type of Account: ___ Checking ___ Savings

Routing Number: __ __ __ __ __ __ __ __ __ __ _____% of net check or $_____

Account Number: _____

Financial Institution: _____ Type of Account: ___ Checking ___ Savings

Routing Number: __ __ __ __ __ __ __ __ __ __ _____% of net check or $_____

Account Number: _____

I authorize Health Care ***INNOVATIONS*** to deposit my net salary to the bank and account(s) listed above. This authorization is to remain in force until Health Care ***INNOVATIONS*** receives notification from me of its termination in time and manner that allows ***INNOVATIONS*** and the bank a reasonable opportunity to act upon it. In the event that ***INNOVATIONS*** notifies the bank that funds to which I am not entitled have been deposited to my account in error, I authorize and direct the bank to return said funds to ***INNOVATIONS*** as soon as possible. If the funds erroneously deposited to my account have been drawn from that account so that return of those funds by the bank to ***INNOVATIONS*** is not possible, I authorize ***INNOVATIONS*** to recover those funds by deducting the amount erroneously paid me from any future payments from ***INNOVATIONS*** until the amount of the erroneous deposit has been recovered, in full. I understand that I will be responsible for any bank service fees that result from invalid or closed account information.

Employee Signature: _____ Date _____

Forward completed form to the payroll department of Health Care ***INNOVATIONS***, 7701 Grand River Suite 100, Brighton, MI 48114. Phone number 810-227-7544, Fax number 810-227-4665.