

First Name: _____ **Last Name:** _____

I authorize AMN Healthcare to initiate electronic credit entries, and if necessary, debit entries and adjustments for any credit entries in error, to my checking and/or savings accounts each pay period. I confirm that my name is on the account(s) provided. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

Signature: _____ Date: _____ Account Holder Social Security # ____-____-____

Attach a voided check, and/or an account verification form for each account. Verify account and routing numbers with your financial institution. A direct deposit can not be set up without receiving this account verification.

First Account

Please select one of the following options. If you choose the "Partial" option, indicate the dollar amount to be deposited. If you choose the "Percentage" option, indicate percentage of net pay to be deposited.

Entire amount Partial: \$ _____ . _____ Percentage: _____ %

Financial Institution

Type of Account: Checking Savings

Name _____

Street _____

City _____ State _____ Zip _____

Telephone Number _____ - _____ - _____

Account Number (On Bottom Of Check) _____

Bank Routing Number (9 Digits) _____

Second Account

Please select one of the following options. If you choose the "Partial" option, indicate the dollar amount to be deposited. If you choose the "Percentage" option, indicate percentage of net pay to be deposited.

Net check after deposit to First Account (above) Partial: \$ _____ . _____ Percentage: _____ %

Financial Institution

Type of Account: Checking Savings

Name _____

Street _____

City _____ State _____ Zip _____

Telephone Number _____ - _____ - _____

Account Number (On Bottom Of Check) _____

Bank Routing Number (9 Digits) _____

