ERINOAKKiDS
Centre for Treatment and Development

Parent Reimbursement
AUTHORIZATION FOR DIRECT DEPOSIT

NAME OF DEPOSITOR: **ErinoakKids Centre for Treatment and Development**
1230 Central Parkway West
Mississauga, Ontario
L5C 0A5

CLIENT (CHILD) NAME: _____

ACCOUNT HOLDER NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

AUTHORIZATION: I hereby authorize ErinoakKids to deposit directly to the account indicated below. This authorization will be in force until ErinoakKids is instructed to stop direct deposits.

_____ _____
Signature **Effective Date**

WE REQUIRE THE FOLLOWING BANKING INFORMATION:
-BANK #
-TRANSIT #
-ACCOUNT #
For Direct Deposit. Attach a print out of your account information from your banking institution, or a void cheque here.

_____ _____ _____
Transit # **Bank #** **Account #**

IF YOU HAVE A CHEQUING ACCOUNT
ATTACH VOID CHEQUE HERE

PLEASE NOTE: If the information which you submit is incorrect, the deposit will be rejected by the bank and you will not be paid until the following month when your banking information has been corrected. Please call Client Financial Services Clerk (905) 855-2690 ext. 2467 if you require more information.

REVISED – November 2017