

**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.