

Hope Medical Clinic, Inc.

P.O. Box 980311, Ypsilanti, MI 48198-0311

Phone: 734-484-2989 Fax: 734-484-6825 E-mail: info@thehopeclinic.org

AUTHORIZATION AGREEMENT FOR AUTOMATIC CREDITS/DEBITS

I hereby authorize Hope Medical Clinic, Inc. (HMC) to withdraw \$_____ (debit entry) monthly from my account listed below, to start _____, _____ (Month, Year) and to continue until I notify HMC to discontinue. I also authorize any necessary deposits (credit entries) to my account listed below, to correct any errors that may occur.

FINANCIAL INSTITUTION	*TRANSIT/ABA NO.	ACCOUNT NO.	TYPE OF ACCOUNT
_____	_____	_____	CHK ____ SAV ____
FINANCIAL INSTITUTION ADDRESS _____			
CITY, STATE, ZIP _____			

The authority is to remain in full force until HMC has received notification from me of its termination in such time and manner as to afford HMC and BANK OF ANN ARBOR a reasonable opportunity to act on it.

NAME _____

ADDRESS _____ CITY, STATE, ZIP _____

PHONE (h) _____ (w) _____ E-MAIL _____

SIGNATURE _____ DATE _____

*Nine-digit number that appears to the left of the account number on the bottom of a check.

Please include a voided check with authorization.

For Office Use Only:

Hope Clinic ID _____

HOPE

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