**Student Accounts Direct Deposit Authorization**

Complete this form to indicate what account you wish to use for student credit balance reimbursements.

Student Name:_____

Type of Account (select one)

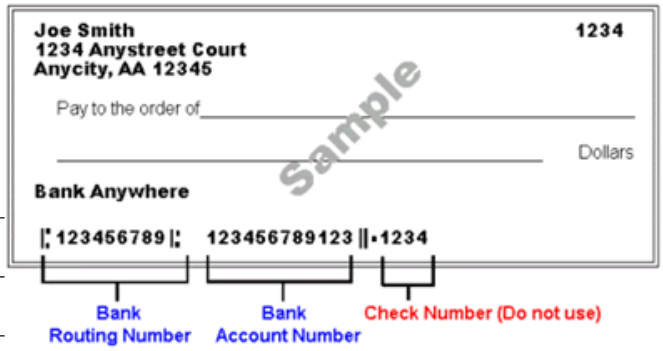
☐ Checking

☐ Savings

Name of Bank:_____

Account Number:_____

Routing Number:_____




I authorize Bryan Medical Center and the Financial Institution to deposit credit balances from my student account into the checking or savings account as indicated. This authorization will remain in effect until Bryan College of Health Sciences Student Accounts Department, has received written notification from me of its termination or change and will cancel any previous Direct Deposit Authorization. I understand that Student Accounts will process this change within a reasonable amount of time after the written notification is received. This termination or change will not affect any deposits processed prior to receipt of the written notice of termination or change.

Signature:_____

Date:_____

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FOR CANCELATION OF THE PREVIOUSLY AUTHORIZED DIRECT DEPOSIT TO THIS ACCOUNT

Please cancel my direct deposit:

Signature:_____

Date:_____

Please return completed form to FA@bryanhealthcollege.edu