



LI Head Start

98 AUSTIN STREET,
PATCHOGUE, NY 11772
631-758-5200
631-758-2953 HR FAX

Authorization to Terminate Direct Deposit

Authorization Agreement

Print Employee Name (Primary): _____ **Site:** _____

Print Joint Account Name: _____

I hereby request that my direct deposit to my (Check one): Checking, Savings be terminated

Effective _____. I no longer wish to pursue this option.

Account Information

Name of Financial Institution: _____

Account Number: _____ Checking Savings

A separate form is needed for additional transactions

Signature

Authorized Signature (Primary): _____ **Date:** _____

Authorized Signature (Joint): _____ **Date:** _____