Authorization for Direct Deposit of Student Credit Balances

☐ **New Enrollment** ☐ **Cancellation** ☐ **Change Account Information (check one)**

I hereby authorize Eastern Virginia Medical School (EVMS) to activate, cancel, or change direct deposit, per my selection above, and, if necessary, to make any such withdrawals as may be necessary to correct any deposits made to my account in error, with the named financial institution for the account number specified below. This authorization will remain in effect until it is either cancelled or changed in writing, or until I graduate, withdraw, or are dismissed from EVMS, whichever may come first. A new authorization must be completed if I change my account or change financial institutions. Any termination or change must be received in such time as to afford EVMS and financial institution reasonable opportunity to act on it.

Student Information

Name: ______________________________

Address: ______________________________

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Phone #: ______________________________

Email: ______________________________

Program: __________ **Class Year:** _____

Account Information

Type of Account (Check one): **Checking** ☐ **Savings** ☐

Name of Financial Institution: ______________________________

Account #: ______________________________

Routing #: ______________________________

Please Attach Voided Check
Or
Deposit Slip

I understand that if I fail to provide complete and accurate information on this form or if my deposit is rejected by the financial institution, I will not receive any electronic credit for refunds owed to me but will receive a paper check mailed to the address EVMS has on file, which may take additional time. I understand it is my responsibility to ensure that funds are in the designated bank account before any withdrawals are made. I agree and understand that neither the Board of Visitors of EVMS nor any officer or employee thereof shall be held responsible or liable for any inadvertence or error in withholding or transmitting my residual refunds to the financial institution I have indicated.

Date____________________ Signature ______________________________