ST. EDWARD THE CONFESSOR SCHOOL

EXTENDED CARE ACH MONTHLY PAYMENTS

Name_____ Monthly Amount $_____September 1 – May 1

I hereby authorize St. Edward the Confessor School, hereinafter called CUSTOMER, to initiate debit entries to my

___Checking Account or ____Savings account

indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account on the 1st day of the month from September 2022 - May 2022. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Bank Name_____

Branch / City, State _____

Routing Number _____Account Number_____

This authorization is to remain in full force and effect until CUSTOMER has received written notification from me of its termination in such time and such manner as to afford CUSTOMER and DEPOSITORY a reasonable opportunity to act on it.

Name_____ Date_____

Signature_____

NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.