



ACH/Direct Debit Authorization Form

Name on Account: _____

Bank Name: _____

ABA Routing Number: _____

Account Number: _____

Account Type: _____ Checking _____ Savings

Dollar Amount: \$ _____

Withdrawals will occur:

_____ the 1st of each month, beginning _____, 20____

_____ the 18th of each month, beginning _____, 20____

I certify that the above information is true and correct, and I authorize Southern Arkansas University Foundation, Inc. (SAUF) to electronically debit the designated bank account. This authority remains in force until SAUF receives written notification requesting a change or cancellation.

Signature

Date

I hereby cancel ACH Direct Debit Authorizations for the above referenced account.

Signature

Date

Attach voided check here.