MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

ACCOUNTS PAYABLE ONLY
DIRECT DEPOSIT AUTHORIZATION FORM
(Please Type or Print)

PLEASE CHOOSE: ☐ Individual ☐ Business ☐ Employee

TRANSACTION TYPE - Section 1

☐ New Set-Up (Sections 2, 3, 4 & 6)	☐ Change Account Type (Sections 2, 3 & 4)
☐ Change Financial Institution (Sections 2, 3 & 4)	☐ Cancellation (Sections 2, 3 & 5) Change Email
☐ Change Account Number (Sections 2, 3 & 4)	☐ (Sections 2, 3, & 6)

PAYEE IDENTIFICATION - Section 2

Employee ID Number, Social Security Number or Federal Employer's Identification Number (FEIN)			
Individual or Business Name	Individual or Business Phone Number		
Street Address	City	State	ZIP Code

AUTHORIZATION FOR SETUP, CHANGES OR CANCELLATION - Section 3

I authorize the Medical University of South Carolina to deposit by electronic funds transfer payments owed to me by the Medical University of South Carolina and, if necessary, debit entries and adjustments for any amounts deposited electronically in error. The Medical University of South Carolina shall deposit the payments in the financial institution and account designated below. I recognize that if I fail to provide complete and accurate information on this authorization form, the processing of the form may be delayed or that my payments may be erroneously transferred. I understand if my account is closed, I will not receive payment until my financial institution returns the funds to the University. I acknowledge that direct deposits to the designated account must comply with the provisions of U.S. law, as well as the requirements of the Office of Foreign Assets Control. I affirm that the entire payment amount is not subject to being transferred to a foreign bank account.

I consent to and agree to comply with the National Automated Clearing House Association Rules and Regulations as they exist on the date of my signature on this form or as subsequently adopted, amended, and repealed. This authority is to remain in full force and effect until the Medical University of South Carolina has received written notification from me/my organization of its termination in such time and in such manner as to afford the Medical University of South Carolina and Depository Institution a reasonable opportunity to act on it.

Authorized Signature	Printed Name	Date

FINANCIAL INSTITUTION (Individuals/Employees please attach a voided check) - Section 4

Financial Institution Name	City	State
ABA/Routing/Bank Number (For example, see Instructions)	Account Number	Type of Account ☐ Checking ☐ Savings

CANCELLATION - Section 5

Reason

E-MAIL ADDRESS - Section 6

(E-mail address is to be used for electronic remittance advice)

E-mail

For Office Use Only: Vendor Location Code

Revised 7/20/16

Return To: MUSC Accounting Services P.O. Box 250817 Suite 505 Harborview Office Towers Charleston, SC 29425 or via fax at (843) 792-3401.