



# DIRECT DEPOSIT APPLICATION AND AUTHORIZATION /CHANGE FORM

 New Application Change of Financial Institution

## IDENTIFICATION

Legal Name/ Corporate Name of Applicant

Vendor # (if known)

Address

City

Province

Postal Code

Telephone

Fax

Contact Name

Title/Position

## BANKING INFORMATION

**ATTACH VOID CHEQUE HERE**  
**\*\* MUST BE PRE-PRINTED \*\***

**\*\* If applicant's name and address are not pre-printed on the cheque then we require the bank complete the following with their Stamp:**

Name of Institution \_\_\_\_\_

Address \_\_\_\_\_

Institution Code \_\_\_\_ \_

Branch Number \_\_\_\_ \_

US Routing Number \_\_\_\_ \_

Account Number \_\_\_\_ \_

Financial Institution Stamp

## REMITTANCE

An email address is required in order to receive remittance advice with payment detail information:

Email Address: \_\_\_\_\_

***Note: Remittance advice emails are sent from: [Corporate.e-commerce@RBC.com](mailto:Corporate.e-commerce@RBC.com)***

## AUTHORIZATION

By signing below, the undersigned:

- \* authorizes Island Health to deposit any (non-payroll) payments due by Island Health directly into the abovementioned account
- \* agrees to promptly notify Island Health within seven (7) days of any changes to the banking information herein provided by filling in a new Direct Deposit Application and Authorization Form to modify the present request.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Send Completed form to Island Health Accounts Payable at [APVendorMaint@islandhealth.ca](mailto:APVendorMaint@islandhealth.ca)