



## Electronic Fund Transfer Authorization

New       Change

I authorize International Health Services to debit my (our) account monthly the amount below at the depository financial institution as indicated below.

Amount per month \$ \_\_\_\_\_ Monthly transfer date  1st  15th

Checking       Savings

Bank name \_\_\_\_\_ Account # \_\_\_\_\_

Routing # \_\_\_\_\_

### **Your information:**

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

This authorization is to remain in effect until International Health Services receives written notice from me to terminate the transaction. It will take about three (3) weeks before the first gift can be processed and may take up to three (3) weeks to process changes once the agreement has been operating.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Mail this form along with a voided check to:**

International Health Services  
P.O. Box 265  
Southeastern, PA 19399

(610) 935-6030

**Thank you**