**AUTOMATED CLEARING HOUSE (ACH)**

**AUTHORIZATION AGREEMENT**

I (we) authorize Cooper University Hospital, hereinafter called the Company, to initiate credit entries to my (our) account at the Financial Institution indicated below.

Name on Account

Receiving Bank Name

City, State, Zip

Account Number

**CHECKING - SAVINGS -**

**MONEY MARKET**

Type Of Account **(Circle One)**

ABA Routing Transit Number **(9 digits)**

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

BY SIGNING BELOW, I/WE (“APPLICANT”) CERTIFY THAT ALL INFORMATION PROVIDED ON AND WITH THIS FORM OR HEREAFTER FURNISHED BY US OR ON OUR BEHALF IS TRUE, CORRECT AND COMPLETE AND THAT I/WE ARE AUTHORIZED TO EXECUTE THIS FORM ON BEHALF OF THE APPLICANT. Applicant(s) are aware that any knowing or willful false statements for purposes of influencing the actions of EPP or its ODFI’s (Bank) can be a violation of federal law 18 U.S.C sec. 1014 and may result in a fine or imprisonment or both. You are authorized to make all inquiries you deem necessary to verify the accuracy of this statement either directly or through any agency employed by the Bank for that purpose. Applicant and Principals authorize the Bank to obtain credit reports, and agrees to provide any additional information that the Bank may require to process this application. Applicant and Principals also authorize the Bank to obtain copies of its tax returns and information from the Internal Revenue Service and other taxing authorities, and agrees to execute whatever forms the Bank requests to obtain such information.

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\*\*Name/Title (Please Print) \*\*Company Name

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\*\*Authorized Signature \*\*Date

Name/Title (Please Print)

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\*\*Contact Name/Phone Number \*\*Contact Email Address (Please Print)

\*\***REQUIRED FIELDS. INCOMPLETE FORMS WILL NOT BE ACCEPTED**

**Please return form to: Office Use Only**

Cooper University Health Care Date validated:

1 Federal Street Suite NW 400B Vendor contact:

Camden, NJ 08103 Validated by:

Attn: Accounts Payable

Fax: 856-382-6558