Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Kudzu Medical, Inc.** to initiate automatic deposits to my account at the financial institution named below. I also authorize **Kudzu Medical, Inc.** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Kudzu Medical, Inc.** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Kudzu Medical, Inc.** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking ☐ Savings ☐

Employee Name (please print): _____

Last 4 digits of SSN: _____

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (if Joint): _____ Date: _____

Please attach a voided check and return this form to the Payroll Department.

FAX: 864-272-0436

e-mail: payroll@kudzustaffing.com

mail: PO Box 51627 Piedmont, SC 29673

Go Green. Go Paperless.