AUTO-DEBIT AUTHORIZATION FORM
EXTENDED CARE

I (we) hereby authorize St. Patrick School, hereinafter called SCHOOL, to debit Monthly Extended Care Amounts seven days from date of monthly invoice from my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit the same to such account. Specific date of collection will appear on monthly invoice cover email.

______________________________ __________________________
(Financial Institution Name) (Branch)

____
(Address) (City/State) (Zip)

______________________________ ____________________________
(Routing Number) (Account Number)

TYPE OF ACCOUNT: ____**CHECKING** ____**SAVINGS**

This authority is to remain in full force and effect until SCHOOL has received written notification from the authorized individual or individuals who have signed below, of its termination in such time and manner as to afford the SCHOOL and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

______________________________ ____________________________
(Print Individual Name) (Print Individual Name)

______________________________ ____________________________
Signature Signature

______________________________ ____________________________
Date Date

__________________________Family

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM!