Send Completed form to: *Island Health Attn: Physician Compensation*

Email: Physician_comp@viha.ca

Phone # 250 755-7691 ext 53852

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 cheque than Please have the bank complete the following with their Stamp:**

Name of Institution ____________________________

Address ____________________________

Institution Code ___ ___ ___

Branch Number ___ ___ ___ ___ ___

Account Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Financial Institution Stamp

REMITTANCE INFORMAITON

How would you prefer to receive the payment details? (please check one and provide email address if applicable)

☐ No remittance advice necessary

☐ E-mail address ____________________________

Note when email received it will be from: 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: ____________