



*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:**

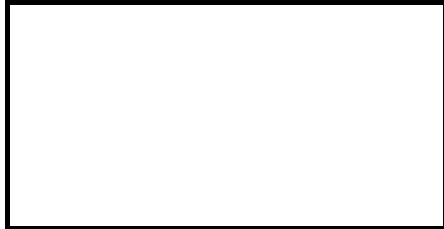
Name of Institution \_\_\_\_\_

Address \_\_\_\_\_

Institution Code \_\_\_\_\_

Branch Number \_\_\_\_\_

Account Number \_\_\_\_\_



**Financial Institution Stamp**

**REMITTANCE INFORMATION**

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: \_\_\_\_\_