



ACH Authorization Form

CREDIT/DEBIT AUTHORIZATION FORM

I (we) hereby authorize Deaf Missions to initiate entries to my (our) checking/savings account at the financial institution listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Deaf Missions is notified by me (us) in writing to cancel or change it, in such time as to afford Deaf Missions and the financial institution a reasonable opportunity to act on it.

(Name of My Bank/Financial Institution) *[Please Print]*

(Address of My Bank/Financial Institution – Branch, City, State & Zip) *[Please Print]*

(Signature)

(Date Signed)

(My Name) *[Please Print]*

(My Address – Street/PO Box, City, State & Zip) *[Please Print]*

(Email Address) *[Please Print]* OR (Phone Number __Voice __TTY __Fax)

Amount: \$ _____ per month Circle withdrawal date preference: 5th 20th

Please include a personalized voided check or deposit slip from the above account.

Please return this form to:
Deaf Missions
21199 Greenview Road
Council Bluffs, IA 51503

Contact:
Joe Mathis / jmathis@deafmissions.com
Mavis Brink / mavisb@deafmissions.com
712/322-5493 (Voice/TTY)
712/322-7792 (Fax)