Electronic Funds Transfer Request Form

Payee (Vendor) Information

***Name:** _____ ***Tax ID/SSN #:** _____

***Address:** _____

_____ **** Required Field***

***City/ST/ Zip:** _____ _____ _____

***Contact:** _____ ***Phone: ( )** _____

***E-mail:** _____ **Fax: ( )** _____

Financial Institution Information

(All submissions must include this form, filled out in its entirety, AND a voided check in order to be processed. Estimated turnaround time for completed submissions is 45 calendar days. Please submit via email to: EFTforms@ccpcares.org)

**** Please notify the Finance Department via the above email if this information changes ****

***Bank Name:** _____

***Bank Address:** _____

***City/ST/Zip:** _____ _____ _____

ABA/ROUTING NUMBER

ACCOUNT NUMBER

***Company Authorization for EFT/Wire Transfer**

_____ _____

Authorized Signature *Printed Name*

_____ _____

Title *Date*

Internal Use Only

Verified by Finance: _____ **Date:** _____

Initiated by: _____ **Date:** _____

Vendor updated by: _____ **Date:** _____

Form: Rev: 20160328