



**Compassion
Evangelical
Hospital**

Agreement for Electronic Funds Transfer (ACH)

Compassion Evangelical Hospital
P.O. Box 870
Southfield, MI 48037

CEH's account #

CEH's routing #

Donor authorization (select one)

- New authorization
 Change contribution amount
Selecting this voids all other agreements

Effective date: _____ / _____ / _____

- Change contribution date
 Change financial institution account
 Discontinue electronic contribution

Name of donor (please print):

Phone:

Address:

Email:

City:

State:

ZIP:

Regular contributions (select one)

- Semi-monthly (transferred on the 5th and 20th)
 Monthly (transferred on either the 5th or the 20th)
 CIRCLE ONE: 5th 20th
 Quarterly (5th day of every 3rd month beginning _____)
 Annual (Date _____ / _____ / _____)

Breakdown of contribution

Fund name	Amount
<i>(Surgical ward, Missionary name, etc.)</i>	
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

****Total amount per contribution \$ _____**
 (**Must equal the breakdown of contribution)

****Total amount of breakdown \$ _____**
 (**Must equal total contribution)

Money will be transferred directly from the institution listed below.

Bank/Institution name: _____

- Checking account (attach a voided check for this option) Savings account

Routing #

Account #

I authorize Compassion Evangelical Hospital to process debit entries to my account. I have attached a voided check. This authority will remain in effect until I give reasonable notification to terminate this authorization.

Authorized signature on my account: _____ Date: _____ / _____ / _____

Mail form to Compassion Evangelical Hospital, P.O. Box 870, Southfield, MI 48037. Please attach a voided check.