RxWound
Hard-To-Heal Wound Experts

Authorization for Direct Deposit

I hereby authorize RxWound LLC to initiate automatic deposits to my account at the financial institution named below. I also authorize RxWound LLC to make withdrawals from this account in the event that a credit entry is made in error. (Account Holder will be notified prior to a withdrawal being made.)

Further, I agree not to hold RxWound LLC responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me, by my financial institution, or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until RxWound LLC receives written notice of cancellation form me or my financial institution, or until I submit a new direct deposit form to the Accounting Department at hr@rxwound.com.

Primary Account Information

Name of Financial Institution: ____

Routing Number: ________________________ Company Name: ___________________________

Account Number: ________________________ Checking ☐ Savings ☐

Secondary Account Information

Name of Financial Institution: ____

Routing Number: ________________________ Company Name: ___________________________

Account Number: ________________________ Checking ☐ Savings ☐

Amount to deposit in Secondary Account per pay period: _______________

Signature

Authorized Signature (Primary): ____________________________________ Date: ______________

Authorized Signature (Joint): ____________________________________ Date: ______________