Choose ONLY ONE (1) of the following options:

Pick up check in office:

_____ _____ _____
Print name above Sign name above Date

Mail your paycheck to your home:

By signing below, you are authorizing American Medical Personnel to mail your paycheck to the address you have provided. Please allow five business days for your check to arrive via snail mail. Please be aware that American Medical Personnel does not accept responsibility for your paycheck once it leaves our office. That means that you accept the responsibility for any lost or stolen paychecks. Should you require a replacement paycheck, your signature authorizes us to deduct $30 from your replacement check in order to pay the stop payment fee to the bank.

Address _____
City _____ State _____ Zip _____

_____ _____ _____
Print name above Sign name above Date

ACH/direct deposit your paycheck to your account:

Name of Bank _____ Routing # _____
Branch Address _____ Account # _____
City _____ State _____ Zip _____

By signing below, you are authorizing American Medical Personnel to initiate electronic credit entries, and if necessary, debit entries, into the account named above. You also understand that ACH/direct deposit will remain in force until you have provided American Medical Personnel with written authorization to terminate your ACH/direct deposit. Please allow 3-5 full business days for paycheck funds to be deposited into your account.

_____ _____ _____
Print name above Sign name above Date

Paycard:

_____ _____ _____
Print name above Sign name above Date