

# AUTHORIZATION FORM

Organization Name: ICR SANITARY  
 P.O. BOX 1963  
 PRESCOTT, AZ 86302 OR EMAIL ICRSDAZ@GMAIL.COM

FOR OFFICE USE ONLY	CUSTOMER #	DATE
<b>Type of authorization:</b> <input type="checkbox"/> New authorization <input type="checkbox"/> Change payment amount <input type="checkbox"/> Change payment date <input type="checkbox"/> Change banking information <input type="checkbox"/> Discontinue electronic payment		
Last Name		First Name
Address		
City		State                      Zip
Email Address		
<b>MONTHLY PAYMENT:</b>  Date for monthly withdrawal: <b><u>AUTO PAY IS RAN</u></b> <b><u>THE 15<sup>TH</sup> OF EACH QUARTER!</u></b>  Date of first payment: ____/____/____    Amount of monthly payment: \$ _____		
<b>CHECKING / SAVINGS</b>	Please debit payment from my (check one): <input type="checkbox"/> Savings Account (contact your financial institution for Routing #) <input type="checkbox"/> Checking Account (staple a voided check below)	Routing Number: _____ <b>Valid Routing # must start with 0, 1, 2, or 3</b>  Account Number: _____ <div style="font-size: small; text-align: center;">             ⑆ 23456789 ⑆ 23 ⑆ 23456 ⑆ 000 ⑆              └──────────┬──────────┬──────────┘              Routing Number    Account Number    Check Number           </div>
	I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.  Authorized Signature: _____ Date: _____	

*If using a checking account, please attach a voided check to the bottom of this page.*