Financial Services

Electronic Funds Transfer (EFT) Authorization

Accounts Payable
760 Topsail Road
Mount Pearl, NL Canada A1N 3J5
Telephone: (709) 752-4764 Fax: (709) 752-4541
www.easternhealth.ca
accounts.payable@easternhealth.ca

Please complete all fields

Reset Form

Transaction Type:

☐ New ☐ Cancellation ☐ Change of Information

Request Date: DD/MONTH/YYYY

Vendor Information

Vendor Name:____________________

Remittance Name (if different than above): ____________________

Remittance Address:____________________

City/Town:__________ Province:_____ Postal Code:________ Telephone: (____)________

Remittance Email:____________________

Contact Name:____________________ Telephone: (____)________

Banking Information (Please attach a void cheque or bank account details)

Bank Name: ____________________

Bank Address:____________________

City/Town:__________ Province: ________ Postal Code:________

Transit Number: ☐☐☐☐☐ Institution Number: ☐☐☐ Account Number: ☐☐☐☐☐☐☐☐☐

Authorization

I (we) hereby authorize Eastern Health (EH) to direct payments electronically to the bank account specified here. I (we) acknowledge that the origination of the EFT transactions to my (our) account must comply with the provisions of Canadian Law. This Authorization Agreement is effective as of the date above and is to remain in full force and effect until EH receives notification of termination. I (we) agree to submit an updated EFT Authorization Agreement to EH for the cancellation of this agreement or to make any changes to the information provided within this agreement. EH will not be held liable for deposit errors as a result of incorrect financial information from the vendor.

Authorized Signature:____________________

Printed Name:____________________

Title: ____________________ Telephone: (___) ________ Date: DD/MONTH/YYYY

Scan and e-mail the completed form and voided cheque or bank account details to: accounts.payable@easternhealth.ca.
If you have any questions or concerns about completing this form, please contact us at the contact information above.

The individual and financial information identifiable on this form collected by Eastern Health is used only for the purpose of payment of vendor invoices and will not be disclosed to anyone other than the claimant or his/her legal representative.

For Office Use Only

Vendor Number:________ Date: DD/MONTH/YYYY Name:__________ Signature:__________