

Campus After School Program

2901 Campus Rd. Brooklyn, N.Y. 11210

(718) 421-7575

CHECKING/SAVINGS WRITTEN AUTHORIZATION FORM

I (we) hereby authorize Campus ASP Inc. to initiate entries to my (our) checking/savings accounts at the financial institution listed below (THE FINANCIAL INSTITUTION), and, if necessary, initiate adjustments for any transactions credited/debited in error. A \$30 charge will occur if your payment is denied by your bank.

Child's Name: _____

(Name of Financial Institution)

(Address of Financial Institution Branch, City, State, & Zip)

Please Circle Type of Account: Checking Savings

(Routing Number)

(Account Number)

Amount _____ Date _____ Amount _____ Date _____

Amount _____ Date _____ Amount _____ Date _____

(Consumer Name PLEASE PRINT)

(Consumer Address PLEASE PRINT)

(Signature)

(Date)

If you should need to notify us of your intent to cancel and/or revoke this authorization you must contact us 1 week prior to the questioned debit being initiated. Please call 718-421-7575 or email at info@campusasp.com Monday-Friday from 10:00am to 6:00pm.