



ONTARIO COUNCIL OF HOSPITAL UNIONS

REQUEST FOR DEBIT BY ELECTRONIC FUNDS TRANSFER (EFT)
APPLICATION FORM

PLEASE PRINT CLEARLY

CONTACT INFORMATION

Form with fields: Local/Contact Name, Address, City, Province, Postal Code

BANKING INFORMATION

Form with fields: Name of Financial Institution, Type of Bank Account, Branch Number, Institution Number, Bank Account Number, Email address for notice

Authorization:

Please sign below to confirm that you are authorizing OCHU to begin withdrawing payments for your invoices from the account mentioned above.

Name _____ Signature _____ Date _____
Position: _____

APPLICATION CAN BE RETURNED BY MAIL, FAX OR EMAIL
DO NOT FORGET TO INCLUDE YOUR VOID CHEQUE

Ontario Council of Hospital Unions
261 Gerrard Street East, Toronto, ON M5A 2G1
Attention: Secretary-Treasurer
Tel.: 416-599-0770 Fax: 416-599-3982
admin@ochu.on.ca

INTERNAL USE ONLY

Form with fields: Vendor #, Entered by: