ASSOCIATION OF MEDICAL FACILITY PROFESSIONALS

ACH VENDOR FORM

Dear Vendor:

Please complete the ACH set up form below so that we may arrange for electronic payments. We believe this is a safer and more expedient way for you to receive your payments.

Please complete this form, and email it, along with your completed W9, to our Accounting Team at accountant@gmpartners.org. Your information will be held secure and in the strictest of confidence.

ACH BANKING INFORMATION

COMPANY NAME: _____

COMPANY ADDRESS: _____

PRIMARY CONTACT: _____

PRIMARY CONTACT EMAIL: _____

REMITTANCE EMAIL (if different than primary contact): _____

BANK NAME: _____

BANK ABA ROUTING NUMBER: _____

BANK ACCOUNT NUMBER: _____

BANK ADDRESS: _____

AUTHORIZED NAME/TITLE: _____

SIGNATURE: _____ DATED: _____