

Electronic Funds Transfer (EFT) Authorization Form

Transaction Type New  Change Information

Supplier Information
 Supplier Name: _____
 Remittance Name: _____
(If different from Supplier Name)
 Remittance Email Address**: _____ @ _____
**UHN will send an email notification detailing the invoice number(s), invoice amount, and the total dollar value of the payment to the email address specified above.
 Contact Name: _____ Phone Number: _____

Banking Information (enclose a Void Cheque OR Bank Letter)
 Bank Name: _____
 Branch Name & Street Address: _____

Street Address City Province Postal Code Phone Number
Account Information:

Institution Number Transit Number Account Number

By executing this form, the Supplier hereby authorizes University Health Network ("UHN") to electronically pay any amounts owing by UHN to the Supplier from time to time, and agrees:

- That this authorization will remain in full force and effect until revoked by Supplier by providing UHN with at least 10 days prior written notice.
- That UHN will not be required to pay any late fees if the funds remitted are not credited to the Supplier's account through no fault of UHN.
- That UHN will not be required to pay any fees to the Supplier's bank in relation to the transfer of funds.
- The Supplier will promptly return by either cheque or credit note any over-payments made by UHN.
- To promptly advise UHN of any changes to information contained in this form.
- To provide all notices pertaining to this authorization to:

MAIL	OR	E-MAIL
University Health Network		ap@uhn.ca
Attn: Accounts Payable		
200 Elizabeth Street, RFE 2		
Toronto, Ontario		
M5G 2C4		

ACKNOWLEDGED AND AGREED TO THIS _____ DAY OF _____, 20_____

Authorized Signature: _____
 Printed Name: _____
 Title: _____