

**AUTHORIZATION AGREEMENT FOR AUTOMATIC DEBITS OF DONATIONS
(ELECTRONIC FUNDS TRANSFER)**

I (We) hereby authorize **TEAMS for Medical Missions** to initiate a monthly debit entry in the amount(s) listed below, from the account at the financial institution named below, and authorize the institution to debit the below named account for the same. This authorization is to remain in full force and effect until I/we notify TEAMS for Medical Missions in writing to terminate the deduction.

Your name(s) _____

Street Address _____

City _____ State _____ Zip Code _____

Daytime Phone _____ E-mail Address* _____

*Optional. When appropriate, we may use your email address to contact you in regard to your donation.

Financial Institution Name _____

Phone Number _____ Type of account (circle one): Checking Savings

Routing Number* _____ Account Number* _____

*if you are unsure of the correct routing and account numbers, please check with your financial institution.

I (We) would like to give monthly to the following missionaries, funds and/or projects:

NAME _____ \$ _____ Account No.* _____

NAME _____ \$ _____ Account No.* _____

NAME _____ \$ _____ Account No.* _____

NAME _____ \$ _____ Account No.* _____

NAME _____ \$ _____ Account No.* _____

*Optional. Please fill in if you know the account number.

Make transfers on the 5th or 20th of the month, beginning (month/year): _____ / _____

Signature _____ Date _____

Signature* _____ Date _____

*Two signatures are required if the account requires two signatures on checks or withdrawals.

Please remember to:

- **Include a voided check** (or in the case of a savings account, include a deposit slip)
- *Keep a copy of this form for your records*
- *Mail the signed original to:*

TEAMS for Medical Missions, P.O. Box 215, Macungie, PA 18062

*Contact Barb Will - barb@T4mm.org or 610-398-0070 – if you have any questions
about giving by Electric Fund Transfer
or if you wish to change your EFT contributions in the future*

Thank you for your support!