



EFT AUTHORIZATION FORM

DATE: _____

I/we authorize Eastern Illinois University to initiate Electronic Funds Transfer (EFT) from my/our bank account on the 5th of every month. This authorization is to remain in effect until the authorizing person named below has given 30 days written notification of termination of this contract to Lauren Clapp.

DONOR INFORMATION (please print):

Name: _____

Street Address _____

City/State/Zip _____

Telephone _____

Gift Designation _____ Amount _____

Check One: One-time Deduction _____ Monthly Deduction _____ (\$5 is minimum allowed for EFT)

Name(s) on Bank Account _____ / _____

Signature(s): _____ / _____

BANK INFORMATION

Bank Name _____

ABA Routing # _____ Account # _____

City/State/Zip _____

Contact Person * _____ Tele. # _____

Type of Account: _____ Checking _____ Savings

PLEASE ATTACH A VOIDED CHECK (or SAVINGS ACCOUNT DEPOSIT SLIP)

RETURN TO: Lauren Clapp
Attn: Foundation Accounting
600 Lincoln Avenue
Charleston, IL 61920

* The person at the Bank who handles EFT transaction if you know, otherwise leave it blank