



Electronic Funds Transfer Form

Please complete the following form and return to the Paul Carlson Partnership, 8303 W. Higgins Rd., Chicago, IL 60631.

Name: _____

Address: _____ Phone: _____

City/State: _____ Zip Code: _____

I hereby authorize the business office of the Paul Carlson Partnership to automatically withdraw from my checking account the monthly amount stated below. I understand and accept that this will begin in the month I have stated below and will continue until the Paul Carlson Partnership receives written notification from me stating this automatic withdrawal should be terminated. I also recognize that monthly withdrawals will be made during the last week of each month.

Signature: _____ Date: _____

Bank and Account Information

Bank Name: _____ Phone: _____

City/State: _____ Zip Code: _____

Name on the account: _____

Acct#: _____ Routing/ABA#: _____

Giving Information

Monthly amount to withdraw: \$ _____ Month to start: _____

Designation of funds:

Health Microfinance Leadership Training Where needed most

More specific designation, if any _____

Please attach a voided check below