



ACH / EFT

CREDIT/DEBIT AUTHORIZATION FORM

I (we) hereby authorize **Associated Pharmacies Inc.** (THE COMPANY) to initiate debit entries to my () checking () savings account(s) at the financial institution listed below (THE FINANCIAL INSTITUTION), and if necessary, initiate adjustments for any transactions credited in error. This authority will remain in effect until THE COMPANY is notified by me (us) in writing to cancel it in such time as to afford THE COMPANY and THE FINANCIAL INSTITUTION a reasonable opportunity to act on it.

(Name of Financial Institution)

(Address of Financial Institution-Branch, City, State & Zip)

(Signature-must be listed on bank account signature card)

(Date)

(Tax ID Number)

(API Account #)

(Store Name-PLEASE PRINT)

(Address-PLEASE PRINT)

Checking/Savings Account Number: _____

Financial Institution Routing Number: _____

(PLEASE ATTACH A VOIDED CHECK FROM THE ACCOUNT THAT YOU WISH TO DEBIT)

211 Lonnie E. Crawford Blvd. Scottsboro, AL 35769 Ph 800.243.8521 Accounting fax 888.560.4442

Apirx.com

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