Sunnybrook
HEALTH SCIENCES CENTRE

ACCOUNTS PAYABLE DEPARTMENT

ELECTRONIC FUNDS TRANSFER FORM

This form should be signed and completed by the vendor.

VENDOR INFORMATION

VENDOR NAME	
CONTACT NAME	PHONE
TITLE/ POSITION	EMAIL

(PLEASE CHECK ONE BELOW)

☐ **EFT** ☐ **CHANGE IN BANKING INFORMATION**

ATTACH VOID CHEQUE, DEPOSIT SLIP OR ANY CORRESPONDENCE FROM THE BANK SHOWING BANK DETAILS.

☐ **EFT TO CHEQUE**

BY EXECUTING THIS FORM, THE SUPPLIER AGREES:

1. THAT THIS AUTHORIZATION WILL REMAIN IN FULL FORCE AND EFFECT UNTIL REVOKED BY SUPPLIER BY PROVIDING SHSC WITH AT LEAST 10 DAYS PRIOR WRITTEN NOTICE.

2. THAT SHSC WILL NOT BE REQUIRED TO PAY ANY FEES TO THE BANK IN RELATION TO THE TRANSFER OF FUNDS.

INDICATE REASON FOR THE CHANGE

NAME OF BANK

ADDRESS STREET

CITY

PROVINCE

BANKING INFORMATION

BANK CODE										
TRANSIT NUMBER										
ACCOUNT NUMBER										

EMAIL ADDRESS IS REQUIRED FOR REMITTANCE ADVICE NOTIFICATION.

I HEREBY AUTHORIZE SUNNYBROOK HEALTH SCIENCE CENTRE ("SHSC") TO PAY THE AMOUNT OWING BY SHSC TO THE ACCOUNT INDICATED ABOVE. I DECLARE THAT THE INFORMATION PROVIDED IN THIS FORM ARE COMPLETE AND ACCURATE.

SIGNATURE _____ DATE _____

For Accounts Payable use only:

Updated contact details by: _____ Date: _____

Updated bank details by: _____ Date: _____

Authorized by: _____ Date: _____

(Form Revised: Oct 11)