AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (ACH CREDITS)

I (we) hereby authorize Medical Marketing Management, Ltd. (doing business as "Honor Medical Staffing") hereafter called COMPANY, to initiate credit entries to my (our) account indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

PLEASE PRINT CLEARLY AND COMPLETELY TO ENSURE PROMPT PAYMENT

DEPOSITORY NAME:_____ BRANCH:_____

CITY:_____ STATE:_____ ZIP:_____

Must check one:

□ Checking Account

□ Savings Account

ROUTING NUMBER:_____ACCOUNT NUMBER: _____

Name(s) on account *: _____

Address: _____
Street City State Zip

Phone: _____Email Address: _____

Signature: _____Printed Name: _____

Date of signature: _____/_____/_____

*** The name on your W9 must match the name on the above account.**
Please ask for a new W9 if there is any change.

IF DEPOSITING TO A CHECKING ACCOUNT - YOU MUST INCLUDE A COPY OF A VOIDED CHECK
WE ARE UNABLE TO PROCESS YOUR REQUEST WITHOUT A COPY OF YOUR VOIDED CHECK.

PLEASE RETURN SIGNED AGREEMENT, VOIDED CHECK & W9 (IF NECESSARY) TO:
OFFICE@HONORMEDICAL.COM OR FAX TO (248) 636-4603

Honor Medical use only:
CN#_____