City School District of
ALBANY

AUTHORIZATION TO DISCONTINUE CURRENT DIRECT DEPOSIT

Employee's Name (PLEASE PRINT) _____

LAST four (4) Digits of your Social Security #: | | | | |

Please be advised that I wish to discontinue my direct deposit with (insert name of financial institution) _____ for account number _____ effective date _____, 20_____.

Employee's Signature:_____ **Date:** _____/_____/_____

PLEASE RETURN THIS FORM TO: City School District of Albany
PAYROLL DEPARTMENT
Academy Park
Albany, New York 12207

FOR OFFICE USE ONLY:

Date Received: _____

Date Inactive: _____

Initials: _____