**Electronic Funds Transfer (EFT) Form**

ALL CELLS ARE MANDATORY. PLEASE TYPE OR PRINT CLEARLY

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Vendor Information** | | | | | | | | | | | | | | | |
| Name | | | | | |  | | | | | | | | | |
| Contact Information | | | | | | Street Address | | | | | | | | | |
| City | | | | | | | | | Province |
| **E-mail Address** (for Remittance Advice) | | | | | | | | | | | | | | Postal Code | Phone Number |
| **Financial Institution Information** | | | | | | | | | | | | | | | |
| **Name** | | | | | |  | | | | | | | | | |
| Branch Address | | | | | | Street Address | | | | | | | | | |
| City | | | | | | | | Province | Postal Code |
| **Bank Account Information** | | | | | | | | | | | | | | | |
| Branch Transit # |  |  |  |  |  | | Bank # | | |  |  |  |  | | |
| Account # |  |  |  |  |  | |  |  |  |  |  |  |  | | |
| **Declaration of Bank Account** | | | | | | | | | | | | | | | |
| In the absence of a voided/unused cheque for identification of my/our bank and account numbers, I/we assume all responsibility for the accuracy of the payment directions, no misdirected payments will be replaced by the Ontario Medical Association. | | | | | | | | | | | | | | | |
| **Signature** | | | | | | **Title** | | | | | | | | | **Date** |

Information collected on this form will be used to administer the electronic transfer payment. It will not be disclosed or used for any other purposes. Only authorized individuals of Ontario Medical Association will have access to the information collected.

If you have any questions, please contact our Finance Department: Phone: (416) 599-2580 Ext: 3030

Fax: (416) 340-2944

Email: Accounts.Payable@oma.org

**Please complete this form and mail to:**

Ontario Medical Association

Finance Department