Hillmann Pediatric Therapy, P.C.

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Shorewood, IL 60404
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Fax: (815) 730-1835

941 Sixth Street
LaSalle, IL. 61301
(815) 224-3261
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1715 DeKalb Ave.
Suite #125
Sycamore, Il 60178
(815) 991-5760
Fax: (815) 991-5766

Authorization for Direct Deposits - Employee Form

This authorizes _____Hillmann Pediatric Therapy, P.C. _____ to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Employee Account Information _____ %

ACCOUNT TYPE (e.g. Check or Savings) _____

EMPLOYEE BANK NAME _____

BRANCH _____

CITY, STATE _____

ACCOUNT NUMBER _____

BANK ROUTING NUMBER (ABA#) _____

Bank Phone Number _____

Bank Website _____

Employee Email Address _____

Please attach voided check, or copy of voided check to this form.

Please call your bank and verify Account Information as well as Bank Routing Numbers to be provided for Direct Deposit.

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

_____

SIGNATURE

_____

PRINTED NAME

_____

EMPLOYEE SS#

_____

D**ATE**