



# AUTHORIZATION FORM

## Pre-Authorized Withdrawal System (P.A.W.S) Monthly Giving Program

FOR OFFICE USE ONLY	ENVELOPE/DONOR #	DATE
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Last Name	First Name	
Address		
City	State	Zip
Phone Number (required)	Email Address	
DATE OF FIRST DONATION: ____/____/____	MONTHLY ON: (check only one) <input type="checkbox"/> 1st <input type="checkbox"/> 15th	DONATION AMOUNT: \$ _____

CHECKING / SAVINGS	Please debit my donation from my (check one): <input type="checkbox"/> Savings Account (contact your financial institution for Routing #) <input type="checkbox"/> Checking Account (attach a voided check below)	Routing Number: _____ Valid Routing # must start with 0, 1, 2, or 3  Account Number: _____ 
	I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.  Authorized Signature: _____ Date: _____	

CREDIT CARD	Please charge my donation to my (check one): <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover Card	
	Credit Card Number:	Expiration Date:
	Name on Card:	
	Billing Address (if different from above):	
	I authorize the above organization to charge my credit card in accordance with the information above.  Signature (as it appears on the credit card): _____ Date: _____	

For more information, please contact Brittany Cekola, Development Specialist, at 616-791-8057 or bcekola@hswestmi.org