



Springfield Education Foundation

PO Box 663 • Springfield OR • 97477

541-726-3243

541-726-9555 fax

ronnel@springfieldeducationfoundation.org

MONTHLY DONOR AUTHORIZATION FORM

Date: _____

I, _____, (print name) authorize the Springfield Education Foundation to initiate debit entries of my checking or savings account (please select below) to Pacific Continental Bank. *I (we) acknowledge that the origination of these transactions to my account must comply with the provision of the US law.*

I would like the donation of \$_____ a month to be taken from my (check one):

Checking Account # _____

Savings Account # _____

My voided check, or copy of it is attached or scanned.

I would like my donation to be taken out on (please check one):

The first of each month

The 15th of each month

This authorization is to remain in effect until the Springfield Education Foundation has received written notification from me to terminate. I will allow for sufficient time for the Springfield Education Foundation a reasonable opportunity to stop payments.

I am aware to change the date, amount or skip a monthly donation I will contact the Springfield Education Foundation five working days before the scheduled entry date.

Signature _____