American Psychiatric Association

VENDOR AUTHORIZATION FOR AUTOMATIC PAYMENT DEPOSITS

◯ **New Agreement** ◯ **Change to a previous Agreement**

I hereby authorize the American Psychiatric Association (APA) to initiate credit entries to the account indicated below and the Bank name listed below to credit the same to such account. **In the event that monies may be deposited to which I am not entitled, I also authorize APA to initiate debits against my account as may be necessary, or to deduct any overpayment from future expense reimbursement payments until the balance of any overpayment is fully recovered.**

RETURN COMPLETED FORM TO (New Address):
American Psychiatric Association
Attn: Accounts Payable
800 Maine Ave, S.W., Suite 900
Washington, D.C. 20024

OR EMAIL TO:
APForms@psych.org

OR FAX TO:
202-380-0827

BANK/ACCT. INFORMATION - US BANKS ONLY

Checking ◯ **or Savings** ◯ **Account**

Bank Name: _____ Branch: _____

Address: _____
City State Zip Code

Bank Transit/ABA #: _____ Account #: _____

Note: DO NOT enter the Bank Transit Number from a Deposit Slip

I understand that the APA cannot and does not guarantee a date by which the amount of my expense reimbursement will be credited to my bank account. **I further understand that APA is not liable for any damages that I may incur by virtue of a failure to credit or of a delay in crediting my account.**

Payee: _____

Contact Name: _____ Phone #: _____
(Vendors Only: Please Fill in Contact Name & Phone Number)

Email- Required: _____ *(You will receive a notice when a payment is made)*

Signature: _____Date: _____

PLEASE REMEMBER TO NOTIFY ACCOUNTS PAYABLE IF THERE IS A CHANGE IN YOUR BANKING INFORMATION.