DVN#002835918

Exclusive Kidz Zone

Kipp Wonder Academy

STUDENT ENROLLMENT CHECKLIST!!!

Please return the following items:

_____**Completed Application**

_____**School Age Health Form** (5yrs & above)

_____**Child Medical Exam Form** (4yr)

_____**Shot Records**

_____**Signed Tuition Agreement**

_____ **ProCare Auto Pay Contract**

Please keep:

ProCare Letter

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

SAVE PRINT RESET

FACILITY/PROVIDER NAME: Exclusive Kidz Zone	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY
(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME: Diane' Daye Child Dev. Center	RELATIONSHIP TO CHILD: Provider	TELEPHONE NUMBERS (CELL, WORK, HOME): 314-773-6300
ADDRESS (STREET, CITY, STATE, ZIP CODE): 2813 Lafayette Ave, St. Louis, Mo. 63104		

COMMENTS ON CHILD'S DEVELOPMENT
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ YES ☒ NO — HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

	CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐FULL TIME OR ☐PART TIME	WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MONDAY	☐	AM PM	AM PM	
TUESDAY	☐	AM PM	AM PM	
WEDNESDAY	☐	AM PM	AM PM	
THURSDAY	☐	AM PM	AM PM	
FRIDAY	☐	AM PM	AM PM	
SATURDAY	☒	AM PM	AM PM	
SUNDAY	☒	AM PM	AM PM	

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☑ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☑ AFTERNOON SNACK ☑ SUPPER ☐ EVENING SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☑ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☐ COLUMBUS DAY (OCTOBER)
☐ VETERANS DAY (NOVEMBER)	☐ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ CHRISTMAS DAY (DECEMBER)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

Exclusive Kidz Zone

DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGEMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
H	I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE.	PARENT/GUARDIAN INITIALS
I	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS
PARENT'S/GUARDIAN'S SIGNATURE ▸		DATE

CACFP REQUIREMENT

FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

Exclusive Kidz Zone
Parent Contract and Policy

Parent Responsibilities:

- Parent/Guardian is responsible for paying Zone fees as stated on fee contract.
- If a child misses a day the full weekly fee is still due.
- Parent/Guardian must see that their child attends day care Monday – Friday.
- Anyone other than parent/guardian dropping off or picking up children must be 18 years or older and is listed on the drop off or pick up form.
- Additional fees will be charged for children left at the Zone past 7pm.
- Parent/Guardian understand that child(ren) will be required to stay home. Or be picked up from the zone if he/she has a fever, contagious illness; or diarrhea. Child cannot come back for at least 24 hours if they had a fever or diarrhea. If child has a contagious illness, they need a doctor's statement in order to return.
- If the person picking up the child is unfamiliar to the staff, the parent/guardian must call the Zone before the child is picked up. Parent/guardian should inform the person that they will need to show identification when they pick up the child and sign a release.
- Parents must fill out, sign, and date the necessary forms when enrolling their child.
- Parent must inform the zone, address change, phone number changes, and emergency contact changes.
- Parent agrees to notify the zone at least five days before child is withdrawn.
- Parent gives permission for child to take part in promotional campaigns that my involve picture taking or videotaping.
- When Kipp Wisdom Academy is closed, Exclusive Kidz Zone is closed.

Zone Responsibilities:

1. The day care center provides childcare services five days a week with the exception of listed **holidays** listed in the Parent Handbook.
2. The Zone is open from 6:00am to 8:00am & 4:00pm to 7:00pm (Mon – Thurs) & 1:30pm to 7:00pm (Friday Only).
3. The Zone will provide:
    a. Developmentally appropriate activities and experience based on State License Regulations and our curriculum.
    b. Emergency accident care while child is in the care of the day care staff
    c. A healthy atmosphere
    d. Breakfast, Afternoon Snack & Dinner
4. To provide a copy of Licensing Rules for Child Day Care Centers in MO, to provide staff trained in childcare.
5. To screen staff for child abuse and neglect and criminal record, accessible to parents upon request.
6. Continue to communicate with family regarding child's development by way of phone calls, conferences, email, daily reports, progress reports...etc.

I AGREE TO ENTER INTO THIS CONTRACT WITH DIAVE' DAYE CARE CENTER. MY FAILURE TO ABIDE BY THE TERMS OF THIS AGREEMENT WILL RESULT IN THE TERMINATION OF THE CHILD CARE SERVICES I RECEIVE.

I HAVE READ AND FULLY UNDERSTAND ALL THE TERMS OF THIS CONTRACT.

_____ _____

(PARENT/LEGAL GUARDIAN SIGNATURE) (DATE)

Tenisha M. Bady

_____ _____

(DAY CARE RESPRESENTATIVE SIGNATURE) (DATE)

Exclusive Kidz Zone
HEALTH CARE POLICIES

The State of Missouri requires (9CSR 30-62.192) your child MUST have a health exam yearly and immunizations must be kept up to date.

If your child shows signs of general discomfort or seems unwell, the temperature will be taken.

There will be **NO EXCLUSION** for children who exhibit the following symptoms. They will be sent home without exception.

1. Fever over one hundred degrees (100 F) by mouth or ninety degrees (99) under the arm.
2. Diarrhea – more than one (1) abnormally loose stool
3. Sever coughing – high pitched croupy sound, whooping sounds
4. Yellowish skin or eyes
5. Pinkeye – tears, redness of eyelid lining, swelling, drainage, pus
6. An infected skin patch(es) – crusty, bright yellow, dry or gummy areas of the skin
7. Vomiting more than once
8. Headache or stiff neck
9. Severe itching of body or scalp
10. Any type communicable disease

The child must be picked up immediately once notified.

The ill child will be kept isolated from the other children until the parent(s) arrives. Be assured that our staff will be attentive to him/her.

When a child goes home with a communicable disease such as: pink eye, lice, rashes, colds with discolored mucus, yellow discoloration in eyes or skin, impetigo, and ringworm, he/she must have a doctor's statement to return.

_____ _____

Parent's Signature Date

_____

Child's Name

Exclusive Kidz Zone AUTHORIZATION SLIP

In order to ensure the safety and well-being of your child we are asking you to initial all items in which you give your permission.

I understand that there will be times when the day care may have to take immediate action for the safety of my child(ren):

_____ I therefore grant permission to Exclusive Kidz Zone to seek immediate medical attention from the nearest healthcare professional or emergent care facility.

_____ I therefore grant permission to said medical professionals to administer any necessary shots (anti-toxin, etc.) or other life stabilizing procedures or surgeries to be administered.

_____ I understand that part of the program of the day care is carried out through field trips, neighborhood walks, and any other field trips outside the daycare facility will require additional fieldtrip form.

It is very important that the form below is filled out so that we may release your child (ren) to the correct person. All the people listed below will need picture identification on file. Your child will only be released to persons with proper identification and a picture ID on file. The person taking your child home must be at least 18 years of age. If the person is not known by the day care staff they will need to provide identification. It is important to notify the day care of any changes in your authorization.

_____Only the following people are authorized to pick up my child from the center.
_____ **I will call the zone the day of change if someone different than the individuals listed below will be picking up my child(ren).**

Authorized to take my child home	**Relationship**	**Phone Number**
1.		
2.		
3.		
4.		

Parent/Legal Guardian's Signature: _____

Date: _____

EXCLUSIVE KIDZ ZONE

Brightwheel Program Acknowledgement

To our parents,

We have implemented a new program to keep our communication on track. We like to keep you informed in an accurate and timely manner. To do so our staff has been trained on an app called brightwheel to ensure that all teachers are communicating directly with their student's parents on issues, incidents, progress, behavior and all your child's needs.

Parent Statement:

I acknowledge and accept Brightwheel as my form of communication concerning my child. My email address is _____.

Parent or Guardian Signature:

_____

Thank you,

Ms. Tamiko Blount
Director

******Partnership with Diave' Daye Child Development Center********

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2019 through June 30, 2020

Dear Parent or Legal Guardian:

Our center is currently participating in the Child and Adult Care Food Program. This program reimburses the center for the partial cost of meals provided to children and allows the center to provide nutritious meals without increasing the center's fees to you. If your yearly income is equal to or below the amount listed for your family size on the chart below, your child is eligible for free or reduced-price meals. If the income is higher than the amount listed for your family size, you do not need to complete the income application.

Family Size	Yearly Income	Family Size	Yearly Income
1	$23,107	5	$55,815
2	$31,284	6	$63,992
3	$39,461	7	$72,169
4	$47,638	8	$80,346
		For each additional Family Member, add	+$8,177

To apply for free or reduced-price meal benefits for your children, you must complete the attached Income Eligibility Form (IEF). Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided; however you are not required to complete the IEF. Notify the center should the household income decrease and/or if the household size increases. A participant may be eligible for free or reduced-price meals. The application is valid until the last day of the month in which the form was approved/dated/signed one year earlier.

Sincerely,

Center Owner/Director

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) XXX-XX-	DATE / /
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER ( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐ MONTH ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐ SNAP (Food Stamp) ☐ TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
Teneshia K. Brady	

MO 886-1314 (2-11) CACFP-205

USDA is an equal opportunity provider, employer, and lender.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.

☐ My child is able to participate in group care but has special health or medical requirements as listed below.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

Exclusive Kidz Zone
Tuition Agreement

☐ Verified for payment to Exclusive Kidz Zone for childcare services through the Family Support Division of the State of Missouri.

Beginning: _____ Ending: _____

The tuition for your child will be $_____ per week plus the payment from the Family Support Division of the State of Missouri.

Parent is to assure that child will be in the care of Exclusive Kidz Zone 90% of the time. Failure to comply with the 90% or perfect attendance monthly may result in one or more of the following:

1. 90 day probation
2. Assessment of the fees
3. Removal from the program

_____ Initials required.

Fee Schedule:

- Before / Aftercare = $65.00 weekly
- Before & Aftercare =$80.00 Weekly
- Before or Aftercare & Friday - $75.00 Weekly

Tuition verified payment for this child is $_____

Tuition registration $_____

Amount due before child's first day $_____ (registration & first week's tuition)

I have read and understand that all fees are due prior to my child's enrollment. My child's tuition Is to be paid a week or 2 weeks ahead based on the payment arrangement I choose. I understand that late fees will be accessed, and I agree to pay:

$ _____ weekly

$ _____ bi-weekly

_____ _____

Parent/Guardian Signature Date:

Jamika Blount

Director's Signature

myprocare®

Dear parent/guardian,

Exclusive Kidz Zone +

Diave' Daye Child Development Center is pleased to offer **MyProcare**, a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.

Log in today!

1. Go to MyProcare.com.

2. Enter your email address (the email you have on file with Diave' Daye Child Development Center) and
choose ***Go***.

3. Enter the confirmation code sent to your email, choose a password, and press ***Go***.

4. Then you may:
    a. View your child's schedule, time card, immunizations and more.
    b. Use the ***Pay*** button to make a payment with your card.

Thank you!

Diave' Daye Child Development Center and MyProcare

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

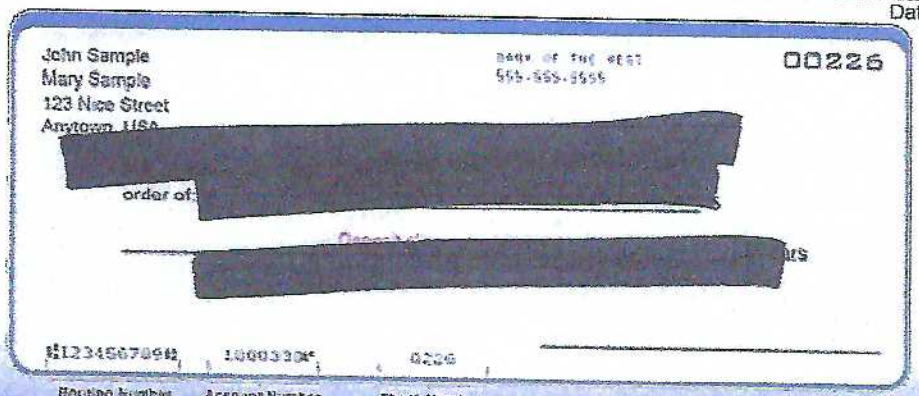
[redacted]

below)

[redacted] Date

For Official Use Only

Date Received
Employee Signature



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