

Extended Care Payment Authorization Form

Student(s) name: _____

I authorize The Saklan School to initiate an automatic withdrawal from the account specified below on or around the 10th of each month for Extended Care expenses. This authorization will remain in effect for the current school year until I cancel it in writing and in such time as to afford The Saklan School a reasonable opportunity to act on it.

Please select complete ONE section and include a voided check, if applicable.

Bank Account:

Name on bank account: _____

Name of bank: _____

Account Type: Checking Savings

Bank account number: _____

Bank routing number: _____

Credit Card:

Name on credit card: _____

Card number: _____

Cardholder Address: _____

Expiration Date: _____

CVV (three-digit code): _____

Signature of Account Holder

Date