

ACH ORIGINATION

CREDIT/DEBIT AUTHORIZATION FORM

I (we) hereby authorize M.A.R.E. Therapeutic Riding Center (THE COMPANY) to initiate entries to my (our) checking/savings accounts at the financial institution listed below (THE FINANCIAL INSTITUTION), and, if necessary, initiate adjustments for any transactions credited in error.

I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

This authority will remain in effect until THE COMPANY is notified by me (us) in writing to cancel it in such time as to afford THE COMPANY and THE FINANCIAL INSTITUTION a reasonable opportunity to act on it.

(Name of Financial Institution)

(Address of Financial Institution - Branch, City, State, and Zip)

(Signature)

(Date)

(Name - PLEASE PRINT)

(Address - PLEASE PRINT)

Set Amount: _____ Due Date: _____ Start Date: _____

Checking/Savings Account Number: _____

Financial Institution Routing Number: _____

(Look between these symbols | : : | on the bottom left of your check)

ATTACH VOIDED CHECK HERE