Authorization for Direct Deposits – Employee Form

This authorizes Comprehensive Autism Partnership, Inc.(the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future. This authorizes the financial institution holding the Account to post all such entries.

Account #1:

Deposit %_____
Account Type (e.g. Checking or Savings)_____
EMPLOYEE BANK NAME_____
BRANCH_____
CITY, STATE_____
ACCOUNT NUMBER_____
BANK ROUTING NUMBER (ABA#)_____

Account #2:

Deposit %_____
Account Type (e.g. Checking or Savings)_____
EMPLOYEE BANK NAME_____
BRANCH_____
CITY, STATE_____
ACCOUNT NUMBER_____
BANK ROUTING NUMBER (ABA#)_____

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

SIGNATURE
PRINTED NAME
DATE