



**OSUWMC Electronic Funds Transfer Set-Up Form**

This form is used to collect the required information to set-up the Electronic Funds Transfer of Funds between The Ohio State University Wexner Medical Center and the vendor referenced below. Vendor to complete the following fields as prompted.

**EFT Request Type:**

New EFT Set-up

Change to Existing EFT Set-up

Cancel EFT

**Vendor Information:**

Vendor Name:

Contact Name:

Billing Address:

Tax ID or last 4 digits of SSN:

Phone:

Email:

Payment Remittance Email:

**Banking Information:**

Bank Name:

Bank Account Number:

ABA Routing Number:

**Requester Authorization**

*By signing below, you authorize The Ohio State University Wexner Medical Center (Accounts Payable) to deliver electronic payment entries into the account of the financial institution designated above, and you authorize the Bank to accept such entries. This authorization will remain in effect until written notice of EFT Change/Cancellation is delivered to The Ohio State University Wexner Medical Center (Accounts Payable).*

Signature of Requestor \_\_\_\_\_ Date

Printed Name of Requestor \_\_\_\_\_ Title

Please print, sign above and return by fax or email:

**OSUWMC / Accounts Payable**

**FAX: (614) 293-2160**

**EMAIL: [accounts.payable@osumc.edu](mailto:accounts.payable@osumc.edu)**

**For Internal Use Only:**

Vendor ID:

Date of Set-up:

Initials: