



Checking Account Automatic Withdrawal Form

I authorize American Leprosy Missions to establish automatic deductions from my checking account on the

5th or the 20th day of each month. *(Please check one.)*

Please initial here: _____

Total amount of my monthly contribution: \$ _____

This automatic contribution is to begin on:

5th or 20th day of _____, _____
(month) (year)

This contribution will continue until I/we request a cancellation or changes in writing. *(Please note it takes four to six weeks to process your information.)*

Signature as required for bank account:

Name - Please Print

Name - Please Print

Signature

Signature

Name(s) on bank account *(please print)* _____

Address _____

City, State, Zip _____

Phone _____ Email _____

Please mail this form and a blank, voided check to:

American Leprosy Missions
One ALM Way
Greenville, SC 29601

Questions? Contact us at 800.543.3135 or amlep@leprosy.org.

