Sutter Health
Sutter Shared Services

This form is used for Automated Clearing House (ACH) enrollments. Please fill out all sections of the form; incomplete forms will not be processed.

Once complete, please submit form to S3VendorServices@SutterHealth.org for processing.

For questions regarding completion of this form, please contact the Sutter Health Shared Services Center at 1-916-297-9300. If for any reason a vendor wishes to cancel or change their ACH/Direct Deposit enrollment status, the onus is on the Vendor to notify Sutter Health.

Sutter Health Accounts Payable Department DIRECT DEPOSIT (ACH) ENROLLMENT FORM					
Vendor Information:					
Vendor Name:					
Vendor TAX ID:					
Vendor Number (If Available):					
Street Address:					
City, State, Zip:					
Contact Person Name:					
Telephone Number:					
Email address:					
Fax Number:					
Submission Date:					
Financial Institution Information:					
Branch Name:					
Account Type :	Checking		Savings		

Bank Telephone Number:	
Routing Account Number (9 digit number):	
Account Number:	

****Form submitted by: ****

Name (Print):_____ **Date:** _____

Signature:_____ **Date:**_____

Please attach voided check/banking information from financial institution here: