

STANDARD SALARY DEDUCTION AUTHORITY

CAREGIVER DETAILS

Surname:		First Name:	
Caregiver No:	E	Division:	ACCORD

I hereby authorise St John of God Health Care to deduct the following from my fortnightly pay effective from: ____/____/____.

Name of Institution	Amount (\$)	Reference / Membership No.

Signed: _____ Date: ____/____/____
(Caregiver)

Office Use Only

Date received by Salary & Benefits: ____/____/____

Date actioned by Salary & Benefits: ____/____/____