STANDARD SALARY DEDUCTION AUTHORITY

CAREGIVER DETAILS

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

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: ____/_____/_____