Confirmation of Banking Information

CLERKSHIP TRAVEL PROGRAM (CTP)

SECTION 1: ACCOUNT HOLDER INFORMATION

Name: ______________________________

Mailing Address: ______________________________

City: ______________ Province: ______________ Postal Code: ______________

Email Address: ______________ Telephone Number: ______________

SECTION 2: DIRECT DEPOSIT INFORMATION

Account Holder's Name (or Corporation Name if applicable): ______________________________

Name of Financial Institution: ______________________________

Branch Address of Financial Institution: ______________________________

City: ______________ Province: ______________ Postal Code: ______________

Branch/Transit Number: ______________________________

Institution Number: ______________________________

Account Number: ______________________________

☐ Void Cheque or Direct Deposit Form Included

Please submit this form and all required documentation to: ctp@ontariohealth.ca

By signing below: I hereby authorize payments for the Clerkship Travel Program to be made by direct deposit to the account indicated on the attached voided cheque.

Signature	Date

Available in accessible format upon request: www.HealthForceOntario.ca/acs

Notice of Collection: Ontario Health collects your personal information under the authority of the Connecting Care Act, 2019, Section 6. All information collected on this form may be used as necessary by Ontario Health for the proper administration of the government-funded Recruitment and Retention Programs, including assessing your eligibility to participate in and receive payment from these programs. The information on this form may also be used by Ontario Health and/or the Ministry of Health for the proper financial administration of these programs, and for conducting research and evaluating program parameters. If you require further information about the collection by Ontario Health, please contact ctp@ontariohealth.ca.

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