AUTHORIZATION FOR DIRECT DEPOSIT- EMPLOYEE FORM

This authorizes Therapeutic Resources to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account (s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

NOTE: Enter your company name in the blank space above. Account # 1
ACCOUNT TYPE (E.G. Checking or Savings):_____

EMPLOYEE BANK NAME: _____

BRANCH: _____

CITY, STATE: _____

ACCOUNT NUMBER: _____

BANK ROUTING NUMBER (ABA#): _____

EMAIL ADDRESS (MANDATORY): _____

Account # 2 IF NEEDED
ACCOUNT TYPE (E.G. Checking or Savings):_____

EMPLOYEE BANK NAME:_____

BRANCH: _____

CITY, STATE: _____

ACCOUNT NUMBER: _____

BANK ROUTING NUMBER (ABA#): _____

EMAIL ADDRESS (MANDATORY:)_____

This authorization will be in effect unit the company receives a written termination notice from myself and has a reasonable opportunity to act on it.

SIGNATURE: _____

PRINTED NAME: _____

ADDRESS: _____

DATE: _____