



# ACH PAYMENT REQUEST FORM

(Please Print All Information)

Requester Name \_\_\_\_\_

Requester Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State Council Name \_\_\_\_\_

### BANK INFORMATION

Bank Name \_\_\_\_\_

Bank Address \_\_\_\_\_

Bank Routing Number \_\_\_\_\_

Bank Accounting Number \_\_\_\_\_

Bank Account Type     Checking                       Saving

Signature \_\_\_\_\_ Date \_\_\_\_\_

### ACCOUNTING USE ONLY:

Vendor Number \_\_\_\_\_ Process Date \_\_\_\_\_

Account Number \_\_\_\_\_ Entered By \_\_\_\_\_

Please return the completed form to the Accounts Payable Department  
Fax 703-297-4378                      Email: [accounts.payable@shrm.org](mailto:accounts.payable@shrm.org)