

PAYROLL DEDUCTION AUTHORITY FORM

Section A: Employee Information

Full Name:	
Position:	
Practice:	

Section B: Deduction Information

I authorise Pro Health Care to deduct the following from my pay:

Item/Name:	
Method:	<input type="checkbox"/> Before-Tax (Salary Sacrifice) <input type="checkbox"/> After-Tax
Frequency:	<input type="checkbox"/> Once-Off <input type="checkbox"/> Fixed-Term <input type="checkbox"/> Ongoing
Total Amount (if applicable):	\$
Pay Cycle Amount (if applicable):	\$
Start Date (or Once-Off Date):	
No. of Pay Cycles (if applicable):	

Section C: Employee Declaration

I declare and affirm that the information provided in this form is, to the best of my knowledge and belief, accurate and complete.

I further agree that, in the event my employment shall terminate, either voluntarily or involuntarily, prior to the full repayment of the total amount above (if applicable), Pro Health Care may withhold the remaining amount owed from my final pay. This is only applicable if Pro Health Care has purchased goods and/or services on behalf of the employee.

.....
Name

.....
Signature

.....
Date

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