Niagara County Audit Department
59 Park Avenue
Lockport, New York 14094

DIRECT DEPOSIT TERMINATION FORM

I hereby consent to and authorize Niagara County to terminate the deposit of my payment(s) in the account in my name, at the bank indicated below:

INDICATE TYPE OF ACCOUNT (CHECK ONE): ☐ CHECKING ☐ SAVINGS
NAME OF BANK:
ACCOUNT NUMBER:
TERMINATION DATE:

VENDOR NAME (PLEASE PRINT)	**TAX IDENTIFICATION NUMBER (last 4 digits)**
VENDOR SIGNATURE	**DATE**
	PHONE NUMBER

This Termination Form must be received in the Niagara County Audit Department, 59 Park Ave, Lockport, NY 14094, at least one week prior to the next payment.

For Office Use Only:

Termination Date: _____ Entered By: _____