STOP PAYMENT REQUEST

Name: ________________________________
ID #: ________________________________
Phone: ________________________________
Check Number: _________________________
Date of Check: _________________________

Reason for Stop Payment:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I am aware of and understand the below terms and conditions associated with requesting a stop payment:

• Once the stop is placed, the check becomes VOID.

• The check CANNOT be cashed, and MUST be returned to the Payroll office if received after the stop payment is issued.

• A replacement check will be issued in 7-10 WORKING days.

________________________________________________________________________
Signature of Employee ___________________________ Date ________________________