



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