VOID CHECK/STOP PAYMENT REQUEST

ATTENTION: ___________________________ FAX # ___________________________

CLIENT INFORMATION:

Client Company: ____

SSN: _____ - _____ - ______ Employee Name: ___________________________

Check Date: __________ Check Number: _________ Check Amount: $_________

☐ VOID CHECK

- Original check must be attached for credit to be issued
- Write void across face of check

Reason for voiding check for this employee: _________________________________
____
____
____

☐ STOP PAYMENT REQUEST

- A fee of $35.00 will be charged. Indicate how this fee will be covered:

☐ Deduct from Employee Check; or
☐ Bill Client for this Charge

Reason for issuing stop payment order: _____________________________________
____
____
____.

_____________________________________ _____________________
Client Signature/Title Date

****Please sign and fax back to (941) 625-0123****

FOR INTERNAL USE ONLY *****Attach Paycheck Record to this Form*****

_____Initials ___/___/___Date 1) Verify Not Cleared

_____Initials ___/___/___Date 2) Verify Issue of Stop Payment

_____Initials ___/___/___Date 3) OK the Reissue (if applicable)

_____Initials ___/___/___Date: 4) Reissued Check