

STOP PAYMENT FORM

FAX: 516-496-3160

EMPLOYEE:

I HAVE NOT RECEIVED THE WEEKLY PAY CHECK REFERENCED BELOW:

CHECK NUMBER: _____ AMOUNT _____
CHECK DATED: _____ W/E: _____
HOURS WORKED: _____ PAY RATE: _____
EMPLOYEE NAME: _____
S.S. NUMBER: _____

I promise that if I DO receive the aforementioned check. I **WILL NOT ATTEMPT TO CASH IT** and will return the check to my office at the earliest time.

By my signature below, I acknowledge that failure to comply with any part of this agreement violates the rights of the office under the law and that the office will take necessary steps to enforce it's rights.

EMPLOYEE SIGNATURE: _____ DATE: _____
OFFICE REPRESENTATIVE: _____ DATE: _____

PAYROLL DEPARTMENT:

LOCATION: _____ BANK A/C #: _____
LOCATION #: _____ DATE: _____
REQUESTED BY: _____
OFFICE: _____
REASON FOR STOP: _____ REPS. INT: _____
_____ SUPV. INT: _____

OPERATIONS ASSISTANT:

CASHED ON: _____ VERIFIED BY: _____
VERIFIED AS OUTSTANDING:
OPERATIONS: _____ DATE: _____
ACCOUNTING: _____ DATE: _____
STOP PAYMENT PLACED BY: _____ ON: _____

PAYROLL DEPARTMENT:

DATE CHECK VOIDED: _____ VOIDED BY: _____
CHECK REISSUE DATE: _____ REISSUED BY: _____
COMMENTS (if any): _____

