



**VOID CHECK/STOP PAYMENT
REQUEST FORM**

Client Name		Department/Division
Employee Name	Social Security Number	Today's Date

Check Date ___/___/___ Check Number _____ Check Amount \$ _____

Replacement Check Requested: _____ Yes _____ No

IF CHECK IS TO BE VOIDED – WRITE VOID ACROSS FACE OF CHECK
And complete the following section

___ VOID CHECK – Original check must be attached for credit to be issued

Reason for voiding check for this employee _____

___ STOP PAYMENT REQUEST – A fee of \$25.00 will be charged by our bank .

Please indicate how the Stop Payment Fee will be recovered:

___ Deduct from Employee Check ___ Bill Client for this charge

Reason for issuing stop payment order _____

Approved By: _____ Date ___/___/___

Title _____

**PLEASE FAX COMPLETED FORM TO THE MBA PAYROLL DEPARTMENT
727.563.1502 or 1.866.896.2528**