



STOP PAYMENT REQUEST

From: Name: _____
 Address: _____
 Phone #: _____
 Fax #: _____

Request stop payment be placed on:

Check #: _____
 Amount: _____
 Check Date: _____
 Payee: _____

Please circle the reason for the stop payment request:

- | | |
|-----------------------------|-------------------------|
| Check Destroyed | Check Washed |
| Stolen Check or Checkbook | Lost Check or Checkbook |
| Wrong Amount | Over Payment |
| Wrong Payee | Payment Disputed |
| Check Lacks Signature | Wrong Address |
| Check Not Received By Payee | Check Issued in Error |
| Check Thrown Away | Miscellaneous |

Additional Comments:

You or anyone else are not authorized to cash the check for which you have requested a stop payment. By signing this form, you acknowledge that you have not / will not give this check to anyone else. If this check has been stolen, a copy of the police report will need to be attached along with a completed affidavit of loss. By signing below, you acknowledge that if the check is received you will return the check to CMHA.

Signature: _____

Date: _____