



Date Faxed \_\_\_\_\_

Please deliver immediately to the Payroll Department

**STOP PAYMENT REQUEST**

**Check Information**

Check Date: _____	Check No. _____	Net Amount of Check \$ _____
Employee Name _____	Social Security No. _____	
Employee Signature _____		

**Client Information**

Client Name _____	Client No. _____
Authorized Signature _____	Printed Name _____
Reason for Stop Payment _____	
_____	

*The employee signature authorizes Employee Professionals, and AMS Staff Leasing Company, to stop payment on said payroll check and request the issuance of a replacement. The employee agrees that if the original check is recovered, it will be returned directly to Employee Professionals. Employee Professionals may accept a signed authorization for an authorized representative of the Client. The Client representative states that the information above regarding the payroll check is true.*

**There will be a Stop Payment Fee of \$30.00 for each check.**

Charge Stop Pay Fee to (check one):  Client  Employee

Replacement Check to be sent by:  Next payroll package = No Cost  
 Overnight Shipping (next day by 10:30AM) = \$15.00 fee  
 Ground Shipping (next day by 5:00PM) = \$10.00 fee  
 Certified Mail = \$6.00 fee

Charge Shipping Expense to:  Client  Employee