

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS
REQUEST FOR STOP PAYMENT AND REISSUE CHECK
For Payroll Issued Checks Only

DATE: _____

I, _____, am requesting that you stop payment on my check dated _____. I have not received this check and would like to have one reissued. If I should receive the original check, I will not cash it. I will return it to the Payroll Division at The University of Texas Southwestern Medical Center for proper handling.

Check was lost or stolen.

Did not receive check in mail due to change of address.

Other: _____

HANDLING FOR REISSUED CHECK: PICK UP MAIL

CURRENT MAILING ADDRESS: _____

PHONE NUMBER: _____

PERSON# or SSN _____

DEPT/PHONE NUMBER _____

PRINT NAME: _____

SIGNATURE: _____

Disclosure Providing a Social Security Number (SSN) is voluntary; however, if your person number is not known, providing your SSN will minimize administrative delays associated with the processing of this form. The University will not disclose an individual's SSN without the consent of the individual to anyone outside the University except as mandated by law.

****REISSUE WILL TAKE FIVE (5) DAYS TO INSURE PROPER HANDLING**.**
RETURN TO PAYROLL, MAIL CODE 9018.
(214) 648-0131 FAX NUMBER,
OR
5323 HARRY HINES BLVD, DALLAS, TX 75390-9018