



STOP PAYMENT REQUEST

AS32

Request Date _____

Please Stop Payment on:

Check #	_____
Payee	_____
LSU ID or Vendor #	_____
Check Date	_____
Net Amount	_____

Reason Check never received in the mail Check was lost
 Duplicate Payment Damaged Check
 Check Date over 180 Days Incorrect Vendor
 Other _____

Action Do not reissue the Check Reissue the Check *

**If Reissue* Contact me at _____.
 I will pick the replacement check up at 204 Thomas Boyd Hall
 Mail the check to:
 Name _____
 Address _____
 City _____ State _____ Zip _____

Requested by _____ Department _____

Approved by _____

I certify that I have not cashed this check and understand that I am responsible for all costs incurred by LSU to stop payment if it has been cashed. In the event I receive this check, I will not cash it. I will return the check to LSU Accounting Services. For a payroll check, I understand that a \$25 stop payment fee will be payroll deducted for a replacement check.

This fee is waived if you decide to enroll in Direct Deposit. To enroll, complete Form AS35, "Authorization Agreement for Direct Deposits" and forward it to Payroll.

Signature of Payee * (Name as on Check) LSUID or Vendor # Date
*** MUST BE SIGNED BY PAYEE IN ORDER TO BE PROCESSED**

FOR ACCOUNTING SERVICES USE ONLY

FOR LSU FOUNDATION USE ONLY

Processed by	_____
Date	_____
Replacement Checks for LSU should be coded to SPH and routed to Stephanie Laquerre in Acct Services.	

Processed by	_____
Date	_____