ASSOCIATED STUDENTS
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CAMPUS ORGANIZATIONS

STOP PAYMENT CHECK REQUEST

Date:_____

Organization Name:_____ **Check Date:**_____

Account Number:_____ **Check #:**_____

Payee Name:_____ **Check Amt:**_____

Reason:_____

_____

_____

_____.

Stop Payment Fee will be charged to the Account: $_____ each.

Account Officer (Print Name): _____

Signature:_____

A.S.G.S.C Staff:_____ **Date:**_____

A.S.G.S.C Manager:_____ **Date:**_____