# Student Stop Payment Request

**VALENCIACOLLEGE**

Please type or print all information requested

Name

Valencia ID#

Address

Check #

City, State, Zip

Phone #

## Reason for Stop Request

☐ Not received in mail

☐ Lost after received in mail

☐ Moved from address currently on file

☐ Other _____

By signing below, you acknowledge that you are requesting that a **STOP PAYMENT** action be initiated for the check listed above. You verify that as of this date, you have not cashed said check. You understand that a replacement check will be issued in approximately ten (10) business days from when you initiated this transaction if eligible. You understand that if you are to receive/find this check you will not attempt to cash and/or deposit said check and in doing so, you will be responsible for all fees incurred.

Signature

Date

**Business Office Use Only**

East ☐         West ☐         Osceola ☐

Please use FAIVNDH for the below information

Term (ex:201710)

Business Office Rep

Amount

Check Date

Check Number