DIVISION OF FINANCE AND ACCOUNTING
VOID/STOP PAYMENT REQUEST

The original direct deposit (ACH) must **not** exceed 5 business days or the original check date **must exceed** 10 business days, in order for the stop payment to be processed. Please fax a clear copy of your photo ID with this form. Allow up to 7 business days from the receipt of this form for a replacement direct deposit (ACH) or check to be completed. If the original check is found after this request has been submitted, do not attempt to deposit it and promptly return it to the **University of Central Florida, Finance and Accounting, 12424 Research Parkway, Suite 300, Orlando, FL 32826**.

To Be Completed by Payee (Please **Print**)	To Be Completed by SAS/AP/Travel:
Payee:_____	Please select the appropriate reason: ☐ Incorrect Check Amount ☐ Incorrect Payee ☐ Duplicate Payment ☐ Check Stolen ☐ Incorrect Address ☐ Check Never Received
PID/VendID#:_____	Other: _____
_____ Current / Correct Mailing Address	Original Check is in our possession (**check**): ☐ Yes ☐ No
_____ City State Zip Code	Voucher#_____
Phone #:_____	Check /ACH#:_____ Vendor ID#:_____
Email Address: _____	Check /ACH Amount: _____ Check/ACH Date: ____/____/____

I acknowledge with my signature below that I accept additional banking fees charged by my banking institution, if I have attempted to cash the original check.

Requestor's Signature: _____ **Date:** ____/____/____

Requestor's Name (Print): _____

Approved by: _____ **Date:** ____/____/____

Please request UCF Financials action by placing an "X" on one of the following void types:

Void/Reissue/Attachment (VRA) ☐ Void/Hold(VH) ☐ Void/Release Liability(VRL-UCF02 ONLY) ☐