Florida Clinical Practice Association, Inc.
Stop Payment Request

RESET

Please issue a stop payment on the following item(s):

Check # _____ Vendor _____

Check Amount _____ Check Date _____

Reason _____

Person Requesting Stop Payment: _____

Phone Number: _____

I understand that once the stop payment is complete, I will need to prepare a new voucher to have another check issued.

Authorized Signature: _____ Date: _____