

DISTRICT _____

FAX NO. _____

EFT REVERSAL/STOP PAYMENT/CANCELLATION REQUEST

TODAY'S DATE ___/___/___

PAYPERIOD END DATE ___/___/___

BORO/SCHOOL

CHECK DATE ___/___/___

EMPLOYEE NAME _____ TITLE _____

SOCIAL SECURITY NO. [] [] [] - [] [] - [] [] [] []

FILE NO. [] [] [] [] [] []

REASON FOR ACTION:

- Terminated Date: _____
- Resignation Date: _____
- Retirement Date: _____
- Leave Without Pay Start Date: _____
- Deceased Date: _____
- Grace Period Start Date: _____ End Date: _____
- Unauthorized Absences Start Date: _____
- Sabbatical Adjustment Required Start Date: _____
- OTHER: Dates: _____

Please select one of the following options:

- Process reversal and cancel future Direct Deposit participation
- Reversal requested for this pay period only
- Process stop and cancel future Direct Deposit participation
- Stop requested for this pay period only
- Cancel Direct Deposit only

School/FMC Contact: _____

Telephone No.: _____

Principal/FMC Authorization: _____

You are required to inform employees of all reversal requests.