



WEST VALLEY-MISSION COMMUNITY COLLEGE DISTRICT Replacement Payroll Check and Cancellation Request

EMPLOYEE COMPLETE THIS SECTION ONLY

Employee Name: _____ G# (G0123456) or last 4 digit of SSN: _____
Address: _____ Phone #: _____
_____ Department: _____

Check Information

Payroll Issue Date:	_____
Check Number:	_____ (if known)
Net Amount on Check:	_____ (if known)

Reason for Replacement

- ☐ Never received check (no change of address)
☐ Never received check (moved/address changed)
☐ Lost after receiving
☐ Other _____

Replacement Check Distribution Method

- ☐ Mail to address above
☐ Pickup in person at District Payroll Office

Employee signature

Date

I declare under penalty of perjury that the foregoing is true and correct.

If the lost check is found after this form has been submitted, it must be returned to the Payroll Office and not cashed.

DISTRICT AUTHORIZATION

Type of **Cancellation** Requested: _____

Requested By: _____ Date: _____

Payroll Supervisor Approval: _____ Date: _____

Replacement Check Information

Payroll Issue Date:	_____
Check Number:	_____
Check Amount:	_____

Date Mailed: _____

Check pick up day and time: _____

Employee Signature