THE RESEARCH FOUNDATION
for MENTAL HYGIENE, INC.

VENDOR CHECK REPLACEMENT REQUEST FORM

E-Mail Form: corcgcc@omh.state.ny.us OR Fax: 518-474-6995

☐ Check Issued Before May 2001 ☐ Check Issued After May 2001

Today's Date: _____ Sender's Name: _____

VENDOR AND CHECK INFORMATION

Name: _____

Address: _____

_____

Check Date: _____ Check Number: _____ Re-Issue Check: ____ Yes ____ No

Reason for Replacement: _____

FOR CENTRAL OFFICE USE ONLY

Outstanding at Bank Institution: _____ Yes _____ No

Date of:
Stop Payment Processed: _____

Replacement Check Number: _____
Replacement Check Date: _____

Initials: _____ Date: _____