

**THE RESEARCH FOUNDATION  
for MENTAL HYGIENE, INC.**

**VENDOR CHECK REPLACEMENT REQUEST FORM**  
E-Mail Form: [coregcc@omh.state.ny.us](mailto:coregcc@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: \_\_\_\_\_