ACH Stop Payment Request

Today's date: _____

Child's Name: _____

Child's team name: _____

Reason for stop payment:

_____

_____

_____

_____

Period(s) or Month(s) requesting for stop payment:

_____

Account Holder's Signature: _____

Account Holder's Name: _____

Approved by Team's Coach: _____

Approved by Atletico's Director: _____

* CANCELLATION OF ACH REQUIRES ***30 DAYS ADVANCE*** NOTICE BEFORE THE 5TH OF THE MONTH (ACH PROCESSING DAY) FOR ATLETICO SANTA ROSA TO PROCESS THE CANCELLATION PER ACH AGREEMENT.
* PLAYER'S PASS CARD WILL BE SUSPENDED AND PUT ON HOLD DURING NON-PAYMENT PERIOD. * STOP ACH FOR INJURY REASON NEEDS A DOCTOR'S NOTE.

ACH Stop Payment Request Form can be mailed, emailed, or faxed to:

Atletico Santa Rosa, PO Box 2215, Santa Rosa, CA 95405 E-Mail: messiassouza@hotmail.com
Fax: (707) 586-6634