ACH Stop Payment Request

Today's Date:_____

Child's Name _____

Child's Team Name: _____

Reason for stopping ACH payment:

_____

_____

_____

Period(s) or Month(s) requesting to stop ACH payment(s):

_____

Account Holder's Name: _____ Phone #: _____

Account Holder's Signature: _____

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) per ACH agreement.

*Player's pass card will be suspended and put on hold during non-payment period.

*Stop ACH for injury reason needs doctor's note.

Ach Stop Payment Request form can be mailed, emailed or faxed to:

Atlético Santa Rosa, PO Box 2215, Santa Rosa, CA 95405

E-Mail to: sheena@optimabuildingservices.com

Fax to: 707-586-6634