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 Signature: ____

Account Holder Name: ____

Account Holder Address (for refund):____

____

Team's Coach Signature: ____

* CANCELLATION OF ACH REQUIRES ***A MONTH ADVANCE*** FOR ATLETICO SANTA ROSA TO PROCESS THE CANCELLATION PER ACH AGREEMENT

* SHORT NOTICE OF ***ACH STOP PAYMENT REQUEST*** WILL RESULT IN A DEDUCTION OF $20 FROM THE REFUND

* 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: sheenachu64@yahoo.com

Fax: (707) 586-6634