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