

Test Strip Buyers STOP PAYMENT FORM

I _____ (Customer Name)
whose address is: _____ (Street)
City) _____ (State) _____ (Zip) _____
(Phone #) _____ am requesting a payment to be reissued to me for the
check listed below for the following reason:

REASON FOR STOP PAYMENT:

- Stolen Lost Never Recieved Prefer Paypal Payment
 Other _____

ORIGINAL CHECK # _____

DATE CHECK WAS ISSUED _____

AMOUNT OF CHECK _____

NAME ON CHECK: _____

PLEAS REPLACE THE CHECK INDICATED ABOVE IN THE FORM OF:

- A New Check Made To Me
 A Paypal Payment to my Paypal Address: _____

My signature below indicates that I am requesting a stop payment on the above check for the reason indicated above. I also understand that any attempt to cash the Original Check after the date of this Agreement, will be fraudulent. I agree that should the Original Check come into my possession, I will mark it "VOID" and return it to Test Strip Buyers at 850 S Erie Blvd. Unit B, Hamilton, OH 45011. Health Care Industries Plus d/b/a Test Strip Buyers may take any legal actions necessary to enforce its rights under this Agreement without prior notice or demand

Signature of Customer: _____

Print Name: _____

Date: _____