

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
WRITE OFF FORM**

<u>UNIT NUMBER</u>	<u>EMPLOYEE NAME</u>	<u>SOCIAL SECURITY #</u>	<u>PAYROLL DATE</u>	<u>GROSS AMOUNT</u>
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AUTHORIZED SIGNATURE

PHONE #

****THIS FORM SHOULD BE COMPLETED, SIGNED AND FORWARDED TO:
CHIEF, ACCOUNTS RECEIVABLE SECTION (ATTACH ALL SUPPORT DOCUMENTS)
COPIES SHOULD BE SENT TO;
ASSISTANT PAYROLL OFFICER
PAYROLL CLERK**

(REVISED 3/21/01)