

CASH ACCOUNTING CHECK TRACER FORM

Date: _____

Dept: _____

Agency: _____

Email to:
ombchecktracer@treas.nj.gov

Address:(incl. PO Box, if available)_____

Telephone: _____

City/St/Zip:_____

Email: _____

Requested by: _____

Original Check Status

(select one)

Lost

Stolen

Endorsed - Yes

Endorsed - No

Never Distributed

Never Received

Date Extension

Mutilated

PAYEE/CHECK INFORMATION

Last Name or Vendor: _____

First/Middle: _____

Street Address: _____

City/State/Zip: _____

Check No: _____

Amount: _____

Check Date: _____

SSN or Tax ID: _____

Tax Year: _____

Comp Week End

Benefit Pd Thru: _____

Instructions: If check cashed - send copy to: payee or this office

(select one)

If check is not cashed - send replacement to: payee or this office

or

Make replacement check payable to:

Hold check for Dept.

(Replacement checks must be issued to original payee)

Name: _____

Street Address: _____

City/State/Zip: _____

Other: _____

Outstanding

Replacement Check Number: _____

Paid

Replacement Check Amount: _____

Stopped

Replacement Check Date: _____