Washington State Department of Social & Health Services
Transforming lives

DSHS Affidavit of Lost, Stolen, or Destroyed Warrant

STATE OF WASHINGTON)
)
)

RETURN TO:
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
OFFICE OF ACCOUNTING SERVICES (OAS)
PO BOX 45842
OLYMPIA WA 98504-5842

OAS Use Only

I, _____ (print name), having been duly sworn, depose and say that I am the proper owner, payee, or legal representative of such owner or payee of the state of Washington's Warrant Number _____, dated _____, in the amount of $_____, and that said warrant has been lost, destroyed or not delivered to me and to the best of my knowledge has not been paid. If the original warrant is subsequently found, I will return the warrant to OAS. I agree that if I (as an employee or vendor) cash both warrants, the full amount listed above may be withheld from my next payment(s).

PAYEE SIGNATURE _____ PAYEE PHONE NUMBER _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

I am a: ☐ DSHS employee ☐ Other:

NOTARY SEAL

State of _____ County of _____

I certify that I know or have satisfactory evidence that _____ (name of person) is the person who appeared before me, and said person acknowledged that (he/she) signed this instrument and acknowledged it to be (his/her) free and voluntary act for the uses and purposes mentioned in the instrument.

Dated _____ Signature _____

Title _____ My appointment expires _____

WITNESSES: REQUIRED ONLY IF PAYEE SIGNED BY MARK (X) ABOVE

1	WITNESS' SIGNATURE	DATE	PRINT NAME (WITNESS' NAME) HERE
	STREET ADDRESS	CITY	STATE ZIP CODE
2	WITNESS' SIGNATURE	DATE	PRINT NAME (WITNESS' NAME) HERE
	STREET ADDRESS	CITY	STATE ZIP CODE

FOR DSHS USE ONLY
WARRANT CANCELLATION AUTHORIZATION

AGENCY/SUB	ISSUE DATE	BIENNIUM		WARRANT NUMBER
NAME				REGISTER NUMBER
ADDRESS CITY STATE ZIP CODE			FUND	AMOUNT
AUTHORIZED BY		TELEPHONE		
			TOTAL	

Original to Office of Accounting Services.