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|  | **DSHS Affidavit of Lost, Stolen, or Destroyed Warrant** |
| STATE OF WASHINGTON ) ) ) | **RETURN TO:**DEPARTMENT OF SOCIAL AND HEALTH SERVICESOFFICE OF ACCOUNTING SERVICES (OAS)PO BOX 45842OLYMPIA 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’sWarrant 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 CODEI 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** |  |