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 Phelan, CA 92329
 P. (760) 868-1212
 F. (760) 868-2323
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REQUEST FOR UNCLAIMED FUNDS

Check Number	Check Date	Amount

EACH CLAIMANT/PAYEE MUST SIGN AN AFFIRMATION OR THE CLAIM WILL BE RETURNED

Full Name or Business Name		Social Security No. or Tax ID	
Mailing Address	City	State	Zip
Daytime Phone		Email Address	

I, _____, certify under penalty of perjury that I am the lawful payee, or authorized representative of the lawful payee, of the aforementioned check, and that I am entitled to receive the money set forth in this claim. I acknowledge and understand the Phelan Piñon Hills Community Services District will cancel the District issued check listed above, causing it to be non-negotiable when a replacement check is issued. I agree to indemnify and hold harmless the Phelan Piñon Hills Community Services District, its officers, and employees from any loss resulting from the payment of this claim.

Signature

Date

** For PPHCSD Office Use Only **			
Date Received:		Amount Approved:	
General Manager Approval:		Date Approved:	
Replacement Check Number:		Check Date:	