Uintah Basin Healthcare

PAYROLL DEDUCTION CHANGE FORM

EMPLOYEE NAME: _____

DATE: _____ EMPLOYEE #:_____

I authorize Uintah Basin Medical Center to deduct and/or make the following changes to my pay.

CANCEL: _____

MISCELLANEOUS: Deduct $_____per pay period for _____# of

pay periods for_____.

CORRECTIONS: Make the following correction to _____

For _____# of pay periods.

Employees Signature: _____