



# Affidavit of Lost, Stolen, or Destroyed Warrant

STATE OF WASHINGTON

) **RETURN TO:**  
 ) DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES  
 ) ACCOUNTING  
 ) PO BOX 40970  
 ) OLYMPIA WA 98504-0970 **OR**  
**EMAIL TO:** [dcyf.clientaccountingunit@dcyf.wa.gov](mailto:dcyf.clientaccountingunit@dcyf.wa.gov)

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 DCYF. 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:  DCYF 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 DCYF 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		
Original to Accounting			TOTAL		