



Manual Check Form

To: Affiliated Payroll

From: _____

Fax: (713) 777-1270

Check #: _____ Check Date: _____

Employee Name: _____

Gross Amount: _____

FICA SS: _____

FICA Med: _____

FWH: _____

Deductions:

| Description | Amount |
|-------------|--------|
|-------------|--------|

| | |
|-------|----------|
| _____ | \$ _____ |
|-------|----------|

| | |
|-------|----------|
| _____ | \$ _____ |
|-------|----------|

| | |
|-----------|----------|
| Net Check | \$ _____ |
|-----------|----------|