REQUEST FOR REFUND

FLORIDA DEPARTMENT OF HEALTH
Human Resources, Headquarters

Date: ____________________________

Employee: ____

Social Security Number: ___________ - ____ - ___________

Company: ____

Deduction Code: _________________ Group Number _______________________________

Pay Period Ending: _________/___________/___________

Additional Pay Periods: ____

Total Refund: $__________________________

Check Payable to: ____

Mail To: GINA LOWELL
DEPARTMENT OF HEALTH
HUMAN RESOURCES, HEADQUARTERS
4052 BALD CYPRESS WAY, BIN BO3
TALLAHASSEE, FLORIDA 32399-1731
Phone: (850) 245-4184, Email: (850) gina_lowell@doh.state.fl.us

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Comments: