



Government of Saint Lucia

SALARY ASSIGNMENT/ DEDUCTION ORDER

TO BE COMPLETED IN TRIPLICATE

- This order replaces previous
- This order is in addition to previous

Date: ___/___/20__

Accountant General
Accountant General's Department
CASTRIES

I, the undersigned employee _____ hereby authorize you to pay
(PLEASE PRINT NAME)
(Please tick appropriate deduction amount below)

_____ dollars
_____ cents (\$ _____)

the full amount
of my salary/gratuity to _____ for the credit of my
(Name of institution/Third Party - PLEASE PRINT)

account # _____ commencing _____ and ending _____
(If applicable) (month/year) (month/year) if applicable

This instruction can only be altered or cancelled according to the condition(s) selected below.

Can be revoked only by the written authorization of _____
(Name of institution/Third Party - PLEASE PRINT)

Can be revoked by the undersigned customer or written authorization of _____
(Name of institution/Third Party - PLEASE PRINT) (whichever is earlier).

Can be revoked only by the written authorization of the undersigned customer.

In consideration of your compliance I hereby release and discharge the Accountant General's Department from any liability it might incur in satisfying these instructions. Kindly imprint your stamp and signature as confirmation of receipt and acceptance of these instructions and return a copy to

(Name of institution/Third Party - PLEASE PRINT)

St. Lucia Nurses Association
P.O. Box 819
Castries
Tel: (758) 452 - 1403

Yours faithfully

Employee's signature

Ministry (PLEASE PRINT)

Department (PLEASE PRINT)

Authorized Signature (Ministry/Department)

Authorized Signature (Institution/Third Party)

*** For use by Government Ministry/Department only ***

EMPLOYEE ID #: _____

Description\Pay Element	Start Date	Stop Date	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Certified Correct: _____

Date: _____

Entered in SmartStream: _____

Date: _____