



JOHN D. KINARD
DISTRICT CLERK GALVESTON COUNTY

**REQUEST FOR NOTICE TO EMPLOYER
TO WITHHOLD INCOME FROM EARNINGS**

Date of Request: _____

Case Number: _____

Court Number: _____

Name of Payor/ Employee: _____

Last 4 Digits of Social Security No. of Employee: XXX - XX - _____

Employer's Name: _____

Attention: _____

Employer's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PERSON RECEIVING THE SUPPORT PAYMENT

Name Payee: _____

Payee's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Requesting Party Name: _____

Signature of Requesting Party: _____

Address of Requestor: _____

City: _____ State: _____ Zip Code: _____

Phone (Work): _____ Phone (Home): _____

SERVICE WILL BE ISSUE UPON PAYMENT OF THE \$15.00 FEE

(TO BE COMPLETED BY CLERK)

Date \$15.00 fee was paid: _____

Issued by: _____
Deputy Clerk