

CHECK REQUEST FORM

Form Number: _____

TO: ACCOUNTS PAYABLE

PROJECT # (required): _____

TODAY'S DATE: _____

Contact Person Name _____ Phone #: _____

PLEASE MAKE CHECK PAYABLE TO: _____

ADDRESS:
(REQUIRED)

CITY, STATE & ZIP CODE:
(REQUIRED)

SOC. SEC. # (Individual):
(REQUIRED FOR CONSULTANT SERVICES)

FEIN #(Co.)
(REQUIRED FOR CONTRACTOR SERVICES)

IN THE AMOUNT OF \$ _____

G/L Code: _____ Project Number: _____

\$ _____

G/L Code: _____ Project Number: _____

TOTAL \$ _____

FOR THE FOLLOWING PURPOSE(S):

- Reimbursement/Individuals
- Consultant Services/Subcontract
- Subcontract/Consortium
- Replenish Emergency Cash
(Accounting Use Only)
- Vendor goods & services
- Other (Please Specify)

PLEASE ADD FURTHER DESCRIPTION REGARDING THE NATURE OF THE EXPENDITURE

ATTACH RELEVANT RECEIPTS FOR REIMBURSEMENT/PAYMENT

Please check one of the following:

- Send enclosure with check
- Please mail check to the above
- Check will be picked up by _____

PRINCIPAL INVESTIGATOR APPROVAL

SIGNATURE & DATE PLEASE

(DATE PICKED UP)

(SIGNATURE OF PERSON WHO PICKED UP CHECK)

Hektoen Accounting Office Use Only

DEPT./FUND NAME _____

P.I. _____

VENDOR # _____ NEW VENDOR? YES OR NO

IF YES, entered ?	Yes or No	Address
	Yes or No	Terms
	Yes or No	1099
	Yes or No	SS # / FEIN #

MERCHANDISE RECEIVED BY: _____

ENTRY MADE BY _____ FUNCTION CODE _____

G/L CODE _____ PROJECT # _____ AMOUNT _____

G/L CODE _____ PROJECT # _____ AMOUNT _____

G/L CODE _____ PROJECT # _____ AMOUNT _____

G/L CODE _____ PROJECT # _____ AMOUNT _____

PAID BY CHECK # _____ CHECK DATE _____