DOWNSTATE
HEALTH SCIENCES UNIVERSITY

PAYMENT REQUEST & VOUCHER

Health Science Center at Brooklyn Foundation, Inc.

(Submit completed form to MSC 1219 or hand deliver to Student Center, Room 2-09)

Check #:
Check date:

CAPITALIZE:

DATE ____________

ORGANIZATION OR DEPARTMENT: ____________

PROJECT NUMBER TO BE CHARGED: ____________

PROJECT TITLE: ____________

TOTAL CHECK AMOUNT: ____________

CHECK DRAWN PAYABLE TO:

PICK UP CHECK AT HSCBF OFFICE

Payee name: ____________

Address: ____________

____

City, State, Zip: ____________

1) attach original invoice
2) attach receipt of goods or services

PURPOSE - BE SPECIFIC ABOUT PURPOSE, AND ATTACH ANY AND ALL NECESSARY ADDITIONAL SUPPORTING DOCUMENTATION, SUCH AS LETTERS OF EXPLANATION/JUSTIFICATION, MEETING MINUTES, CONTRACT, ETC.
NOTE - ADVANCES, WHEN APPROVED, MAY BE ISSUED, HOWEVER RECEIPTS MUST BE SUBMITTED WHEN RECEIVED. FAILURE TO RETURN RECEIPTS WILL RESULT IN ACCOUNT BEING FROZEN.

REQUESTOR:

AUTHORIZED SIGNATURE ____________

Name (please type or print) ____________
Organization Title ____________

WHEN SECOND SIGNATURE IS REQUIRED BY ORGANIZATION:

AUTHORIZED SIGNATURE ____________

Name (please type or print) ____________
Organization Title ____________

DO NOT WRITE BELOW THIS LINE - FOR HSCBF OFFICE USE ONLY

ACCOUNT NUMBER	ACCOUNT TITLE	DEBIT	CREDIT

CHECK RECEIVED BY ____________ DATE ____________ BATCH # ____________