DOWNSTATE
HEALTH SCIENCES UNIVERSITY

PAYMENT REQUEST & VOUCHER

Health Science Center at Brooklyn Foundation, Inc.

(Fill out the Form electronically, print and sign. Mail completed form to MSC 1219 or hand deliver to Student Center, Room 2-09)

Check #:
Check date:

DATE OF REQUEST: _____ REQUESTOR: _____

ORGANIZATION OR DEPARTMENT: HSCBF

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.

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 # _____