



REQUEST FOR PAYMENT

Date of Expense: _____

Person Requesting: _____

Dept. and School Name: _____

Dept. Address or Box #: _____

Contact Person: _____

Telephone Number: _____

Amount Requested: _____

Account Debited: _____

Check Payable To: _____

VCAF Tracking (ACT-710): To or on behalf of a public employee Amount exceeds \$1,000
 (If both apply, form requires VCAF tracking and initial _____)

Reason & Purpose of Expense: _____

Place (if applicable) _____

Persons Present (if applicable) _____

Attach original bill, receipt or request for payment where applicable.

**** As account custodian / Department Head or Director, my signature certifies that this expenditure adheres to the scope and donor intent of this Foundation account.****

Requested by: _____
 Signature of Account Custodian Date

Approved by: _____
 Signature of Department Head or Director Date

Approved by: _____
 Signature of Dean or Designee Date

Approved by: _____
 Chief Financial Officer Date

Approved by: _____
 Foundation President (if required) Date

Approved by: _____
 Authorized Board Member (if required) Date

Check Number: _____ Check Date: _____