LSU Health FOUNDATION NEW ORLEANS

REQUEST FOR PAYMENT

Date of Check Request: _____

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: _____

_____

You are required to attach supporting documentation as outlined in the spending polcies for this account, including, but not limited to, original bills or invoices, receipts, lists of attendees, agreements, etc.

***** 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: _____

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