



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 policies 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 and does not supplant State funding. ****

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: _____
