CCCI PAYMENT REQUEST FORM

(Please pick up your check from the office 1-2 weeks after submitting)

Description	Amount	Account (Accounting Use)
Total Reimbursement:		

Pay to: _____

Check No: _____

Requested by: _____ **Date: _____**

(Print Name)

Check Amount: _____

Signature: _____

Check Date: _____

Authorized Signature: _____

(For any single purchase that is over $100)