St. Clair County Community Mental Health Authority

Credit Card Charge Log

Staff Name:_____ For the Month of:_____

Note: Attach Charge Slips

Date	Name of Vendor	Type of Purchase	**Charge to:**	Comments: (Relationship to Agency Business, if not obvious)	Total Cost

_____ _____

Card Holder's Signature: Date:

_____ _____

Supervisor's Signature: Date:

Finance Form: #07-0251
Reviewed Date: 1/1/2024
Policy Ref: #07-001-0005