St. Clair County Community Mental Health Authority

Emergency Check Request

Person Requesting Check:	
Date of Check Request:	Dollar Amount of Check:
Vendor Name:	
Reason for Request:	
Chief Financial Officer/Designee Signature:	Date
E and it a Trans Manufact City of	
Executive Team Member Signature:	Date

*Please obtain both signatures (Finance and Executive team) before you turn your request in for payment. *

Finance Form: #07-0252 Reviewed Date: 1/1/2024 Policy Ref: #07-001-0005