St. Clair County Community Mental Health Authority

# Check Request

**Please complete the following:**

Date of request:_____

Name of requestor:_____

Make check payable to:_____

Address:_____

_____

Check amount $_____

Account Number:_____

Description of purchase/ Items:_____

_____

_____

Requestor signature:_____

Approved by:_____

*All receipt(s) MUST be attached to this form if items have already been purchased. If purchase has been approved but not yet made, please submit receipts to the Accounts Payable Clerk as soon as possible.*

***PLEASE DO NOT WRITE BELOW THIS LINE/ ACCOUNTS PAYABLE ONLY***

Doc Date (Period Date):_____

Vendor ID:_____

Doc #:_____

P.O. No.:_____

Amount: $_____

Distribution:_____

Distribution:_____