SOUTH ALABAMA MEDICAL SCIENCE FOUNDATION

DIRECT PAY REQUEST

(Do not use for University purchases)

DATE	REQUEST NUMBER

G/L Acct (Subcode)	Dept #	Fund # (1,2,3, or 4)	MSF Project #	Responsible Person (Assigned #)	Amount

Requestor Information	Payee Information
NAME:	NAME:
DIVISION:	STEET:
DEPT:	CITY:
BLDG:	STATE: ZIP:
PHONE:	PHONE: FAX:
FAX:	SS#:

Return check to (select one): ☐ Other (Specify): ☐ Department ☐ Bursar ☐ Payee

QTY	DESCRIPTION	UNIT OF MEASURE	UNIT COST	TOTAL
				0.00
				0.00
				0.00
				0.00
				0.00
				0.00

1. After departmental approvals are obtained, submit original copy of this form to the **COM** Business/Accounting Office (CSAB 104).
2. Attach either an original invoice or original receipt.
3. For membership and subscriptions, attach the order or renewal form.

Total Due 0.00

Special Instructions: _____

Approvals

Requestor's Signature _____ Date: _____

Department Approval _____ Date: _____

COM Bus Office Approval _____ Date: _____

SAMSF President Approval (Over $500) _____ Date: _____

Other Admin Approval (Over $2000) _____ Date: _____

Revised: Septmber 9, 2009