



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:

STREET:

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

1. After departmental approvals are obtained, submit original copy of this form to the **COM** Business/Accounting Office (CSAB 269).

2. Attach either an original invoice or original receipt.

3. For membership and subscriptions, attach the order or renewal form.

Total Due

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: