REQUEST FOR CHECK
DEACONESS HOSPITAL
Evansville, Indiana 47747

To Finance

Date* ____________________
Amount* $ ____________________

Payable To* ____________________

Address 1* ____________________

Address 2 ____________________

City* ____________ State* ____________ Zip* ____________

Give Full Explanation* ____________________

Tax Identification Number (SSN or TIN) ____________ 1099 Required? ____________

ACCOUNT NUMBERS	
Charge To*	Dollar Amount*
_ _ - _ _ _ _ _ - _ _ _ _ _	$
_ _ - _ _ _ _ _ - _ _ _ _ _	$
_ _ - _ _ _ _ _ - _ _ _ _ _	$
_ _ - _ _ _ _ _ - _ _ _ _ _	$

Requested By* ____________ Phone Number* ____________

Administrative Approval* ____________

Controller Approval ____________

Is a separate check required (Y/N)? ____________ Payment Due Date: ____________

Special Instructions:

____

Instructions:

1. All blanks with " * " are required information to process check. Please include complete information.

2. Please attach any documents that must be sent with the check (registrations, letters, etc.) Checks will be mailed from the finance office, they will not be returned to departments.

3. Checks will be printed on Mondays. All invoices and requests received by noon on Thursday can be included with the following Monday's check run.

4. Please denote "Separate Check Required" if for any reason a payment to a vendor would need to be on a separate check than other payments to that vendor

5. Check requests that are not coded with the 11 digit account number and approved by department director or manager will be returned to the department.

RECEIVED BY FINANCE

FORM DATE: 5/20/00, REPLACES ALL PREVIOUS VERSIONS