

**ALDEN-HEBRON S.D. #19
REQUEST FOR PAYMENT**

Date _____ (If reimbursement, use your name in vendor field)

Name of Vendor _____

Address _____

Amount of Check \$ _____ Check Number _____

Invoice # _____

All checks will be sent to vendor unless requested to be returned to originator.

Purpose

Signature of Originator

District Account Number to be Charged

Approved By

Return Check to Originator

Mail Check

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