UNC HEALTH CARE

VOLUNTEER COUNCIL

GRANT REIMBURSEMENT FORM

******PLEASE ATTACH ORIGINAL RECEIPTS/INVOICES TO BACK OF THIS FORM******

Date: _____

Person or vendor to be reimbursed: _____

Department: _____ **Amount to be reimbursed:** _____

Address to send check or phone number to call when check is ready for pick-up:

_____

If payment is to a vendor, please indicate address to send the check:

_____

Assigned grant number: (found on G-4A, Grant Approval Form) _____

This form must be mailed or hand delivered to: Department Volunteer Services, Memorial Hospital, G-100.

Date Paid: _____ Check Number: _____ Approved: _____