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: _______________