VOLUNTEER COUNCIL

G-3 GRANT REIMBURSEMENT FORM

****PLEASE ATTACH ORIGINAL RECEIPTS/INVOICES TO 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) _____________________

Date Merchandise Received __________________ Signature __________________________

This form may be mailed or hand delivered to: Volunteer Services Department, CB7600,  
Memorial Hospital, G-100 or emailed to Linda.Bowles@unchealth.unc.edu.

Date Paid: _______________ Check Number: __________ Approved: __________

Form G-3: 7/16; 7/18; 5/19; 7/20; 6/21