

St. Clair County Community Mental Health

**Check Request**

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**Please complete the following:**

Date of request: \_\_\_\_\_

Name of requestor: \_\_\_\_\_

Make check payable to: \_\_\_\_\_

Address: \_\_\_\_\_

Check amount \$ \_\_\_\_\_

Account Number: \_\_\_\_\_

Description of purchase/ Items: \_\_\_\_\_

Requestor signature: \_\_\_\_\_

Approved by: \_\_\_\_\_

*All receipt(s) MUST be attached to this form if items have already been purchased. If purchase has been approved but not yet made, please submit receipts to the Accounts Payable Clerk as soon as possible.*

**\*PLEASE DO NOT WRITE BELOW THIS LINE/ ACCOUNTS PAYABLE ONLY\***

Doc Date (Period Date): \_\_\_\_\_

Vendor ID: \_\_\_\_\_

Doc #: \_\_\_\_\_

P.O. No.: \_\_\_\_\_

Amount: \$ \_\_\_\_\_

Distribution: \_\_\_\_\_

Distribution: \_\_\_\_\_