MEDICAL COLLEGE of Georgia FOUNDATION

Check Request Form

Date _____

Prepared By _____ Amount _____

Department _____ Payee _____

Phone Number _____ Payee Address _____

_____

Fund Number _____ Fund Name _____

Purpose or Justification (all reimbursements for meals, refreshments or entertainment must be accompanied by an *Attachment A*)

Handling Instructions

☐ Pick-Up ☐ Inter-Campus Mail

Email Address: _____ Attn: _____

Location: _____

Department Authorization (2 signatures required)

_____ _____ _____ _____

Signatory 1 Date Signatory 2 Date

_____ _____

Print Name Print Name

MCG Foundation Use Only

Vendor Number _____ Date Received _____

MCGF Approval _____ Date Approved _____

Please submit this form, receipts and supporting documentation to MCG Foundation at 720 St Sebastian Way Suite 150 Augusta, Georgia 30901 (Attn: Accounts Payable)
Contact the MCGF Accounting Department with any questions: (706) 823-5500
Please refer to our Disbursement Policy for additional details located on our website, mcgfoundation.org