



Our Lady of Angels Conference Society of St. Vincent de Paul Check Request/Payment Form

Date of Request:		Case Number:	
		or member reimbursement	

Check Amount:		
Check/Payment made to:		
City:	State: VA	Zip:

Check Memo: <small>(Example: Account Number):</small>	
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Please select the Account(s) for this transaction. Itemize below as needed.		
Housing <input type="checkbox"/> Mortgage <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Rent Utilities <input type="checkbox"/> Telephone <input type="checkbox"/> Water <input type="checkbox"/> Gas (Natural or Propane) <input type="checkbox"/> Electric Food Pantry <input type="checkbox"/> Groceries <input type="checkbox"/> Supplies	Legal Assistance <input type="checkbox"/> Attorney Fee <input type="checkbox"/> License Fees Medical <input type="checkbox"/> Health Insurance <input type="checkbox"/> Medicine/Prescriptions <input type="checkbox"/> Doctor Fee <input type="checkbox"/> Operating Expenses <input type="checkbox"/> Building Material and Repairs <input type="checkbox"/> Office Supplies <input type="checkbox"/> Postage Twinning (Location): _____	Auto <input type="checkbox"/> Insurance <input type="checkbox"/> Registration <input type="checkbox"/> Repairs Projects <input type="checkbox"/> Public Relations <input type="checkbox"/> Thanksgiving <input type="checkbox"/> Toy Drive <input type="checkbox"/> Easter <input type="checkbox"/> Training and Materials Moving Expense Other:

Brief Description, Itemized Expenses and/or special instructions:

Member Name: <small>(Please Print)</small>	
Member Signature:	
Officer Signature: <small>(Required if amount > maximum allowed):</small>	

Office Use Only			
Date Check Prepared:		Check Number:	
Date Electronic Payment:		Payment Made by:	