CCCI PAYMENT/REIMBURSEMENT REQUEST FORM

Date	Description	Amount	Requesting Department
	Total Reimbursement:		

Pay to: _____ **Date:** _____

Requester Print Name: _____

Requester's Signature: _____

Approved by (PRINT & SIGN): _____ **Date:**_____

(Department Deacon's signature required if over $100)

(Deacon Board approval needed if over $500)

For Office Use Only

Check No: _____

Check Amount: _____

Check Date: _____

Responsible Deacon's Print Name: _____

Responsible Deacon's Signature: _____

(Deacon's own request over $100 should be countersigned by other Deacon)