PAYMENT VOUCHER
College of the Atlantic
**Please attach receipts or other backup**

WHO (to pay): ____________________________________________

WHAT (amount to pay): $ ________________________________

WHERE (did it happen): __________________________________

WHEN (did it occur): _____________________________________

WHY (did it happen): _____________________________________

___ Check to be picked up by ________________________________

___ Check to be mailed to this address ________________________

APPROVED BY __________________________________________

BUDGET TO CHARGE

Receipts must be turned in within 60 days to be reimbursed. Thank you!

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