



CHECK REQUEST

Date: _____

Payee: _____

Invoice #: _____

Address to be mailed to:

Amount: _____

Purpose/ PO#: _____

Account Name & FUF# to be charged: _____

Authorized by: _____

(Club Advisor/Officer/ Other Authorized Approver)

Instructions or Comments:

Please submit Check Request with corresponding receipt, invoice and/or instructions to the FSA Office. FSA requires 10 business days to process and issue check.