south cove
community health center

South Cove Community Health Center

Contracted Services Payment Request

Date:_____

Make Check Payable to: _____

_____

_____

_____

Detailed Description of Services: _____

_____

_____

_____

Date	# of Hours	Hourly/Flat Rate	Description	Amount
			Total:	

If payment is not to a corporation please provide:

S. S. #: _____
or
E.I.N.: _____

Submitted By:_____ **Dept. Approval:**_____

Accounting Use Only			
Date Vouchered:			
Check #:		**Account Charged:**	
Check Amount:			
Date Paid:			
Date Mailed:		**Administration Approval:**	

Rev.2/21/02

Instructions: This form is to be completed for all contractors requesting payment for services rendered to South Cove Community Health Center. A detailed description of services must be included above or attached. Completed form must be sent to the Accounting dept. within 45 days of service.