

**MEDICAL LIBRARY GROUP OF
SOUTHERN CALIFORNIA AND ARIZONA**

Request for Reimbursement of Expenses / Payment of Invoice

TO: MLGSCA Treasurer Telephone: (602) 406-3299
c/o Molly Harrington Fax: (602) 406-4171
Health Sciences Library Email:
St. Joseph's Hospital & Medical Center molly.harrington@chw.edu
350 W. Thomas Road
Phoenix, AZ 85013

[] Please reimburse the attached expense (Please attach all receipts and/or documentation.)

[] Please pay invoice:

[] attached

[] to be sent by vendor

Charge this expenditure against _____
(specify office, committee or function)

Receipt or Invoice #	Item or Service Purchased	Amount Paid
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total amount requested/paid:		_____

Date: _____ Signed: _____

Make check payable to: _____

Send check to: _____

In order to comply with federal regulations, please supply the following information for all recipients of checks written to individuals:

Home Mailing Address (if different from above): _____

Telephone #: _____

Social Security #: _____ (only include for personal services above \$600)