Weill Cornell Medical College

PAYMENT REQUISITION FORM

RETAIN COPY FOR DEPARTMENTAL USE

Document Number

Date

PAYABLE TO (Please Print)

Name

SOCIAL SECURITY NO. OR FED. ID NO.

- -

Street

City

State

Zip Code

If CUMC Employee: Telephone (Ext.)

Location

INVOICE #	INVOICE DATE	Description of payment (including Business Reason)	WBS (10 Digits)	FUND (8 Digits)	G/L (6 Digits)	AMOUNT

TOTAL **EXPEDITE PROCESS - PLEASE USE CASHIER OFFICE FOR REQUESTS UNDER $400.00 OR USE DEPARTMENTAL PROCUREMENT CARD FOR PURCHASE UP TO $2,000. PLEASE EXCLUDE NYS SALES TAX.** 0.00

REQUISITIONER SIGNATURE **PRINT NAME** **EXTENSION**

APPROVED/CERTIFICATION BY : I have examined this expenditure business reason and documentation for appropriateness/compliance to WMC procedures.

(See Approval Section)

SIGNATURE **PRINT NAME**

FOR ACCOUNTING USE

DOCUMENTATION AND COMMENT