



SAINT TIMOTHY
CATHOLIC CHURCH
PAYMENT REQUEST FORM

**Attach All Receipts
For Reimbursement**

Requested by: _____

Date Requested: _____ Expense Reimbursement

Ministry/ Program /Purpose: _____

Budget Account (if known) _____

Quantity*	Item Description		Unit Cost/Rate	Total

*Number, Miles, Hrs., etc. Total Due

Payee: Name: _____
 Street: _____
 City, State, Zip: _____
 Phone: _____

For Office Use Only: Date Paid Check Number