LOUISIANA STATE UNIVERSITY HEALTH CENTER-NEW ORLEANS

ACCOUNTS PAYABLE SYSTEM ENTRY FORM

DIRECT PAY CHECK REQUEST

Clear Form

REFERENCE # Revised 07/01/07

PAYABLE TO:

ADDRESS LINE 1

ADDRESS LINE 2

ADDRESS LINE 3

CITY-STATE

(including zip code)

DATE:

CHECK AMOUNT: 0.00

VENDOR NUMBER:

PURPOSE/JUSTIFICATION:

ACCOUNT	FUND	DEPT ID	PROGRAM	CLASS	PROJECT ID	INVOICE #	GROSS AMOUNT	CREDIT AMOUNT
6	3	7	6	6	10			
							0.00	0.00

DEPARTMENT CONTACT (Please Type) **PHONE** **AUTHORIZED BY (DEPARTMENT)**

DEPARTMENT NAME (Please Type) **BUILDING** **APPROVED BY:(DEAN)**

For DP Use Only	Date received	Reroute to Sponsored Projects/Dept		Date Reviewed
		send	return	By:
Audit Timeline				

SYSTEM VOUCHER #