LOUISIANA STATE UNIVERSITY HEALTH CENTER-NEW ORLEANS

ACCOUNTS PAYABLE SYSTEM ENTRY FORM

DIRECT PAY CHECK REQUEST

REFERENCE #

Revised 07/01/07

PAYABLE TO:

ADDRESS LINE 1

ADDRESS LINE 2

ADDRESS LINE 3

CITY-STATE
(including zip code)

DATE:

CHECK AMOUNT:

VENDOR NUMBER:

PURPOSE/JUSTIFICATION:

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

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 #