University of Connecticut School of Medicine
Graduate Medical Education and
Capital Area Health Consortium Check Request Form

Clear Form

Date: _____

Program: _____

Requested by: _____

FOAPAL: [ ] [ ] [ ] [ ]
FUND ORG ACCT PROG

Check payable to: _____ PGY: [ ]

_____

_____

_____

_____

Check to be picked up? ☐ No ☐ Yes Check to be returned to: _____

Check total amount: [ ]

Payment for:

Educational Allowance

[ ] Books
[ ] Phone
[ ] Computer
[ ] Other, describe:
[ ]

Travel

[ ] Registration
[ ] Travel
[ ] Mileage
☐ Attending (from travel allowance)
☐ Presenting (from presenting allowance)
☐ Required by program (program budget)

Program

[ ] Dues/Subscriptions
[ ] Fees
[ ] Functions
[ ] Other, describe:
[ ]

Submit invoice only if paying a vendor directly (Consortium is tax exempt and will submit their tax exempt information with the payment). All other receipts, invoices, etc. must be kept in the Program's office for 5 years.

☐Invoice(s) attached for vendor payment - Federal Tax ID # (if required): _____

☐Receipt(s) maintained in the program office for 5 years

For GME & CAHC use only:
GME #: _____ Date: _____ Approved: _____

CAHC Check #: _____ Date: _____