LSU Health FOUNDATION NEW ORLEANS

REQUEST FOR PAYMENT

Check Request Date:

Person Requesting Payment: _____ **Payment Type:** Check ☐ ACH/Direct Deposit ☐

Dept. Address or Campus Box #: _____ **School/Dept:** _____

Person Preparing the Form: _____

Email:

Payment Amount Requested: $ **Phone:**

Check Payable To:

Fund Number(s):

VCAF Tracking (Act 710): To **or** on behalf of a public employee: ☐ Amount exceeds $1,000.00: ☐

* If both boxes apply, this form requires VCAF tracking and initials: _____

Justification of Expense in Relationship to Fund's Purpose:

Event Date(s) & Location:

Persons Present (If applicable):

Delivery Method (If paper check): Foundation Pick Up: ☐ Campus Mail: ☐ Direct Mail: ☐

•You are required to attach supporting documentation as outlined in the spending policies for this Fund, including but not limited to, original bills or invoices, itemized receipts, list of attendees, agreements, etc.•

• Receipts should be within a 60 day limit. •

APPROVALS:

As Fund Custodian /Department Head/ Director, my signature certifies that this expenditure adheres to the fund scope and donor intent of this Foundation Fund and does not supplant State funding.

Fund Custodian:	(Type) Custodian Name	Custodian's Signature	Date
Dept. Head / Director:	(Type) Dept. Head/ Director	Dept. Head /Director's Signature	Date
Dean or Designee:	(Type) Dean/Designee Name	Dean/Designee's Signature	Date
Senior Vice-Chancellor or LSU Chancellor (if required):	(Type) Senior Vice-Chancellor/LSU Chancellor	Senior Vice-Chancellor/LSU Chancellor Signature	Date
Chief Operating Officer (COO):	Alejandra Guzman COO	COO's Signature	Date
President and Chief Executive Officer (CEO) (if required):	Katie Acuff, Esq. President & CEO	President & CEO's Signature	Date
Authorized Board Member (if required):	Board Member	Board Member's Signature	Date

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