Chagrin Falls
EDUCATIONAL FOUNDATION
CHECK REQUEST and ALLOCATION FORM

IMPORTANT!
- ■ Attach documentation such as invoices or receipts to this form.

Date of request: _____   **Date needed:** _____

Requestor: _____

Amount: _____

Reimbursement to Individual or Direct Pay via Invoice: _____

Description of expenditure: _____

To Whom Shall the Check Be Issued

Name: _____ **Phone #:** _____

Address: _____

_____

Send Check To (if different than above)

Name: _____

Address: _____

_____

SEND OR E-MAIL THIS FORM TO:
Adam Lechman
314 Whitetail Dr.
Chagrin Falls, OH 44022
alechma@gmail.com

INTERNAL:
Approved by: 1)_____Date_____

2)_____Date_____

Invoice #_____   *Date Paid_____*
Check #_____