



Weill Cornell Medical College PAYMENT REQUISITION FORM

SEND ORIGINAL TO WMC ACCOUNTING DEPARTMENT, (INTEROFFICE MAIL BOX 76)

RETAIN COPY FOR DEPARTMENTAL USE

Document Number

Date

PAYABLE TO (Please Print)

Name

SOCIAL SECURITY NO. OR FED. ID NO.

Street

City

State

Zip Code

If CUMC Employee: Telephone (Ext.)

Location

INVOICE #	INVOICE DATE	Description of payment (Including Business Reason)	WBS (10 Digits)	FUND (8 Digits)	G/L (6 Digits)	AMOUNT

TOTAL EXPEDITE PROCESS - PLEASE USE CASHIER OFFICE FOR REQUESTS UNDER \$400.00 OR USE DEPARTMENTAL PROCUREMENT CARD FOR PURCHASE UP TO \$2,000. PLEASE EXCLUDE NYS SALES TAX.

REQUISITIONER SIGNATURE _____ PRINT NAME _____ EXTENSION _____

APPROVED/CERTIFICATION BY : I have examined this expenditure business reason and documentation for appropriateness/compliance to WMC procedures.
(See Approval Section)

SIGNATURE _____ PRINT NAME _____

FOR ACCOUNTING USE

DOCUMENTATION AND COMMENT

