Check/Reimbursement Request Form

Payee Name: _____

Payee Address & Tel #: _____

_____

Reason: _____

_____

_____

Amount: _____ **Date:** _____ **Signature:** _____

PO#: _____ **(required if amount over $75.00)**

Office Use Only

The Church of the Cross
PO Box 278
Bluffton, SC 29910

Approved by: _____

Check/Reimbursement Request Form

Payee Name: _____

Payee Address & Tel #: _____

_____

Reason: _____

_____

_____

Amount: _____ **Date:** _____ **Signature:** _____

PO#: _____ **(required if amount over $75.00)**

Office Use Only

The Church of the Cross
PO Box 278
Bluffton, SC 29910

Approved by: _____