West Michigan Regional Medical Consortium

Expenditure Report

Name and Address Date:

Name of Project:

Project Number: _____ PCA Code or Account #: _____

Date Check Required:

Purpose and Description of Expense (attach all receipts):

1. _____ Acct #: _____ Amount: _____
2. _____ Acct #: _____ Amount: _____
3. _____ Acct #: _____ Amount: _____
4. _____ Acct #: _____ Amount: _____
5. _____ Acct #: _____ Amount: _____
6. _____ Acct #: _____ Amount: _____
7. _____ Acct #: _____ Amount: _____
8. _____ Acct #: _____ Amount: _____

Total: _____

Requestor: _____

Approved by: _____