ST. CROIX VALLEY FOUNDATION

516 Second St., Suite 214, Hudson, WI 54016
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accountspayable@scvfoundation.org

EXPENSE REQUEST FORM

NAME OF FUND:

PAYEE INFORMATION (*you must provide a second signature if requesting personal reimbursement)*

Payee Name:	
Address:	Email/website:
City, State, Zip:	Phone:

DETAILS ON EXPENSE PAYMENT REQUEST

Amount $_____________________

Charitable purpose of payment:____

Special instructions (if any):____

REGULATORY CONFIRMATION

In signing this form, I hereby certify that the goods and/or services described on the attached documentation are accurately described and priced. I hereby submit this request for payment subject to SCVF's review and approval for the charitable purposes or program objectives described above.

Authorized fund advisor signature:____

Printed name of fund advisor:____

Date:__________________________________

Telephone:_______________________________________ email:____

If requesting personal reimbursement, please provide a second signature of a Board or Committee member:

Board/Committee member signature:____

Printed name ____

Telephone:_______________________________________ email:____

Typically, invoices are processed on the second and fourth Wednesdays of the month. Please scan, mail or fox this form, along with receipts/invoices to the contact information above. Please note , an IRS W9 form will be required for all new vendors.

For office use only		
FUND ID:	Account #:	____ entered in FIMS
SCVF Approval Signature:		____ W9 rec'd? (if applicable)