



# HHS PTSA

## Check Request Form

Date: \_\_\_\_\_

\*Issue check to: \_\_\_\_\_

\*In the amount of: \_\_\_\_\_

\*Mailing address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Due date: \_\_\_\_\_

\*Committee: \_\_\_\_\_

\*Requestor's signature: \_\_\_\_\_

\*Committee Head Signature: \_\_\_\_\_

Asterisk (\*) denotes required fields. Signatures required to validate expenses.

Attach supporting receipt(s) or original invoice before submitting to treasurer. Please keep a copy of all paperwork for your records

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For HHS PTSA Use Only:

Date Paid: \_\_\_\_\_

Check #: \_\_\_\_\_

Amount: \_\_\_\_\_