Quin County Community Health Services

P.O. Box 248, Newfolden, MN 56738-0248

Date: _____

PAY TO:

Vendor # _____

Name: _____

Address: _____

_____

DATE	DESCRIPTION	AMOUNT

ITEMIZE FULLY — Give dates, when and where goods were delivered and labor performed.

I declare under the penalties of perjury that I am

_____ of or for _____

(INSERT TITLE OF OFFICE) (INSERT PERSON OR FIRM)

making the within claim; that I have examined said claim and that the same is just and true; that the money therein charged was actually paid for the purposes therein stated; that the property therein charged was actually delivered or used for the purposes therein stated, and was of the value therein charged; that the services therein charged were actually rendered and were of the value therein charged; that the fees therein charged are official and are such as are allowed by law; that no part of said claim has been paid.

_____

SIGNATURE OF CLAIMANT

(Office Use Only)	
ACCOUNT NO.	AMOUNT

_____

Audited and Allowed

Amount of Claim $ _____

_____ 20____

_____

Quin CHS Board Chair