

ST. ELIZABETH'S HSA
CHECK REQUEST / AUTHORIZATION

(Please PRINT or TYPE clearly)

- USE A SEPARATE REQUEST FORM FOR EACH CHECK YOU NEED.

DATE: _____

PAY TO: _____

ADDRESS: _____

* Checks will be mailed to this address unless you indicate otherwise. If there is no address, checks will be left in the school office for the person making request.

AMOUNT: _____

ACTIVITY/REASON : _____

RECEIPTS ATTACHED: Yes _____
No _____ Explain: _____

* If more than one receipt is attached, please itemize in space provided below. Use back if necessary.

BY WHAT DATE IS CHECK REQUIRED: _____

NAME OF PERSON REQUESTING: _____

SIGNATURE OF AUTHORIZATION: _____

RECEIPTS:

NAME: _____ AMOUNT: _____

NAME: _____ AMOUNT: _____

NAME: _____ AMOUNT: _____

NAME: _____ AMOUNT: _____