

Request for Payment



Development Foundation
940 Second Street
Portsmouth, Ohio 45662

PLEASE TYPE OR PRINT – ATTACH ANY PERTINENT INFORMATION

ACCOUNT	Payment Total

DEPT. NAME	DATE
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INITIATED BY	EXT.	NEED CHECKED BY:
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PAYEE

Payee Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Email (optional): _____

Please Allow Three (3) Business Days for Payment Processing

When payment is ready, please (choose one): Mail Payment Directly to payee Notify initiator for payment pickup

INVOICE NO.	DESCRIPTION OF PAYMENT	PAYMENT AMOUNT(S)

NOTE: ALL REQUEST FOR PAYMENT FORMS PAYABLE TO INDIVIDUALS MUST BE ACCOMPANIED BY A FULLY EXECUTED IRS FORM W-9

APPROVED: _____
INITIATOR

DIRECTOR OF DEVELOPMENT

DEPARTMENT DIRECTOR/DEAN