



**DREXEL UNIVERSITY
COLLEGE OF MEDICINE**

In the Tradition of Woman's Medical College of Pennsylvania and Hahnemann Medical College™

CHECK REQUEST

Accounts Payable Department
3201 Arch St., Suite 400
(215) 895-1250

Please type or print legibly.

| | | | |
|--|---|-------|-----|
| 1. Payee Information | Name to appear on check: | | |
| | Address 1 | | |
| | Address 2 | | |
| | City | State | Zip |
| | Is the Payee a U.S. Citizen or Permanent Resident Alien? | Yes | No |
| | Is the Payee employed by Drexel University College of Medicine? | Yes | No |
| | Does the Payee accept credit card payments? | Yes | No |
| Was this payment attempted with a purchasing card? | Yes | No | |
| Does the requesting department have access to a purchasing card? | Yes | No | |

| |
|--|
| Employees or Students |
| Employee ID or Student ID |
| _____ |
| REQUIRED for Employees/Students (Do not use Social Security Numbers.) |

| |
|--|
| Non-Employees or Vendors |
| SSN or TIN _____ (Individuals) |
| EIN _____ (Unincorporated Entities) |
| REQUIRED for Payment Processing |

| | |
|--|--|
| 2. Justification & Delivery | Reason for Expenditure: |
| | |
| | |
| Check Distribution Instructions: | <input type="checkbox"/> US MAIL <input type="checkbox"/> PICK UP <input type="checkbox"/> US MAIL WITH ENCLOSURES |

| 3. Funding Source | Fund Code (6 digits) | Org. Code (4 digits) | Account Code (4 digits) | Activity Code* (4 digits) | Cost Center Title | Amount | |
|--------------------------|----------------------|----------------------|-------------------------|---------------------------|-------------------|--------|--|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | TOTAL | | | | | | |

* Activity Code is Optional. If additional space is required, please attach a separate sheet. **DO NOT** use additional Check Request forms.

| | | | |
|---------------------|--|-----------|------|
| 4. Approvals | P.I. / Cost Center Administrator (Additional signatures required for multiple Cost Center allocations.) | | |
| | Print Name | Signature | Date |
| | Director / Dean | | |
| | Print Name | Signature | Date |
| | President / Vice President | | |
| | Print Name | Signature | Date |

I hereby certify that all of the information provided on this form is true and correct to the best of my knowledge. If the expenditure is funded by a GRANT or CONTRACT, the approver further certifies that the expenditure complies with all applicable cost principles and regulations of the sponsoring entity.

Prepared by: _____ Date _____
Location/Mail Stop _____ Telephone _____

Submit original form to Accounts Payable at the address above with required supporting documentation. To ensure prompt payment, complete the entire form and obtain necessary signatures. Allow 7-10 working days for processing.

| | |
|---------------------------------------|---|
| 5. For Internal Use Only | <input type="checkbox"/> 1099 <input type="checkbox"/> 1042-S |
| | Withhold as: |
| | <input type="checkbox"/> US Backup Withholding |
| | <input type="checkbox"/> 1042 Withholding |
| | Vendor # _____ A.C. _____ |
| Reviewer's Signature _____ Date _____ | |