DWSRF

REQUEST FOR REIMBURSEMENT

SEND ORIGINAL TO: Vendor:

Division of Municipal Facilities

4201 Normandy St., 3rd Floor Address:

Bismarck, ND 58503-1324

A copy will be returned to the vendor with or

following payment. City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Zip

|  |  |  |  |
| --- | --- | --- | --- |
| **CONTRACT INFORMATION (BY VENDOR)** | BUDGET CATEGORY | EXPENDITURES THIS PERIOD | CUMULATIVE EXPENDITURES |
| Contract # DWSRF | Personnel Salaries |  |  |
| Payment Request # | Fringe Benefits |  |  |
| Billing Period: | Travel |  |  |
| From To | Supplies |  |  |
| Rent/Utilities |  |  |
| **PAYMENT AUTHORIZATION (BY DEPARTMENT)**  Grant Title: DWSRF (DWSRF/EPA CFDA 66.468)  Approved for payment - H3662: | Telephone/Postage |  |  |
| Equipment |  |  |
|  | Other: Specify |  |  |
| DWSRF Program Date |  |  |  |
|  |  |  |
| MF Division Director Date | TOTAL EXPENDITURES |  |  |
| Health Department Funding |  |  |
| Administrative Support Date | Less Previous Requests |  |  |
| Balance Due This Billing |  |  |
| PFA Date |  |  |  |
|  |  |  |
| BND Date  Federal Share $  Project Element  Grant # | Payee Certification: I hereby certify that this request accurately reflects expenditures in accordance with an agreement between the above vendor and the ND Department of Health. I understand all supporting documents will be kept on file and available for audit. | | |
| Payee Signature Date | | |