

**SPECIAL OLYMPICS NEW MEXICO, INC.**  
**AREA/LOCAL PROGRAM**  
**CHECK REQUEST FORM**

PROGRAM NAME:		_____ . ____
PROGRAM DIRECTOR:		
PHONE NUMBER:		
DATE OF REQUEST:		

PURPOSE OF CHECK REQUEST (choose one):  
 Advance       Reimbursement       Payment of Attached Invoice

**ADVANCE**

**IMPORTANT NOTE:** ADVANCES CANNOT BE PROCESSED UNTIL THE PREVIOUS *ADVANCE RECONCILIATION FORM* HAS BEEN RETURNED TO THE CHAPTER OFFICE.

REQUESTED AMOUNT:		REQUESTED PAYMENT DATE:	
PURPOSE OF ADVANCE:			

**REIMBURSEMENT / PAYMENT OF ATTACHED INVOICE**

REQUESTED AMOUNT:			
DESIGNATED PAYEE:			
PAYEE'S ADDRESS:		City and State:	Zip Code:

**SUMMARY OF EXPENSES (receipts and/or invoices must be attached)**

DESCRIPTION / EXPLANATION	EXPENSE TYPE	AMOUNT	FOR OFC USE ONLY - GL ACCT #
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
<b>CHECK TOTAL</b>		\$	

THIS COMPLETED FORM MUST BE RETURNED TO THE SONM CHAPTER OFFICE.