SPECIAL OLYMPICS NEW MEXICO, INC.

AREA/LOCAL PROGRAM

CHECK REQUEST FORM

PROGRAM NAME:	SONM Sample Delegation	**SONM.0**
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 #
		$	
		$	
		$	
		$	
		$	
		$	
	CHECK TOTAL	**$**	

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