



# FUND REQUEST FORM

## FOR OFFICE USE ONLY

	<b>AMOUNT</b>	<b>\$</b>
	<b>FUND #</b>	<b>663395-8020</b>
	<b>DATE RECEIVED:</b>	
	<b>DATE PROCESSED:</b>	
	<input type="checkbox"/> <b>PAYROLL</b>	<input type="checkbox"/> <b>A/P</b>
	<input type="checkbox"/> <b>W-9 ATTACHED</b>	<input type="checkbox"/> <b>CHECK REQ ATTACHED</b>

### Instructions for completion of FUND REQUEST FORM

1. Enter all applicable information ***including social security number if being reimbursed through Payroll.***
2. Have Program Director sign form where indicated.
3. Attach **ORIGINAL** receipts and **W-9 if applicable,** to the signed form.  
***NOTE: Completed W-9 must be attached if payment is to a new vendor, or to any person who is not a KHN employee***
4. Mail signed form, original receipts and W-9 (if applicable) to **MEDICAL EDUCATION** for processing.

**IF YOU HAVE ANY QUESTIONS PLEASE CALL THE GRANDVIEW FOUNDATION AT 723-3358**

### Area below to be completed by person requesting reimbursement or payment PLEASE PRINT

Amount Requested: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name of Residency Program: **VASCULAR RESIDENTS FUND**

Expense Description: \_\_\_\_\_

*(If expense is for a conference or course, please include the event name and event date)* \_\_\_\_\_

Make check payable to: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_

Tax ID # (if applicable): \_\_\_\_\_

***NOTE: Completed W-9 must be attached if payment is to a new vendor, or to any person who is not a KHN employee***

Requested by: **X** \_\_\_\_\_

**PROGRAM DIRECTOR**

**X** \_\_\_\_\_

**Director of Medical Education**

**X** \_\_\_\_\_

**Grandview Foundation, VP Development**