

**MILLCREEK COMMUNITY HOSPITAL**  
**CHECK REQUEST**

**ATTENTION: MED ED**

DATE REQUESTED: \_\_\_\_\_

DATE REQUIRED: \_\_\_\_\_

NAME: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

REQUEST: \_\_\_\_\_

AMOUNT: \_\_\_\_\_

SUPERVISOR APPROVAL:

\_\_\_\_\_

\_\_\_\_\_

-----ACCOUNTING OFFICE USE-----

VENDOR # \_\_\_\_\_

PAY DATE \_\_\_\_\_

AMOUNT \_\_\_\_\_

DISTRIBUTION

G/I ACCOUNT NO

AMOUNT

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

VERIFIED \_\_\_\_\_