University of Florida College of Medicine

Expenditure Request

RESET

Requested by _____ Phone # _____

Division _____ Date (mm/dd/yyyy) _____

I certify that all information is factual and accurate and is a proper charge for goods or services received and I am empowered to enter into such transactions on behalf of the division. _____

Authorized Signature

Type

- ☐ Purchase Order
- ☐ Direct Payment
- ☐ Reimbursement (Travel or Other)
- ☐ Deposit

Amount

_____
_____
_____
_____

Business Purpose

Benefit to the State

(Required for Travel Reimbursements)

University of Florida Foundation Fund # **UFF -** _____

(if applicable)

Pay To	Remittance Address	UF ID (if reimbursing)

----------*For Accounting Use Only*----------

Dept ID	Fund	Program	Source of Funds	Account #

Bud Ref	Flex	Project #

Accounting Approval: _____ Date: _____