FAIRVIEW FIRE DISTRICT

19 ROSEMONT BOULEVARD
POST OFFICE BOX 1680
WHITE PLAINS, NY 10607
914-949-2828

VOUCHER

Purchase Order No.

DO NOT WRITE IN THIS BOX

Date Voucher Received

FUND - APPROPRIATION	AMOUNT	
Total		

VOUCHER NO.

Check No.

CLAIMANT'S NAME AND ADDRESS

TERMS

Vender's Ref. No.

Dates	Quantity	Description of Materials or Service	Unit Price	Amount
		For Medicare Reimbursement only		
		(See Instructions on Reverse side)	TOTAL	

CLAIMENT'S CERTIFICATION

I, _____, certify that the above account in the amount of $ _____ is true and correct; that no part has been paid or satisfied; that taxes, from which the fire district is exempt are not included; and that the amount claimed is actually due. I further certify that I have neither claimed nor received Medicare reimbursement from another source either through direct remuneration or through a reduction in the cost of the premium for any health care coverage or other benefit.

Date _____ Signature _____ Title _____

(Space below for Dire District use)

APPROVAL

The above services or material were rendered or furnished to the fire district on the above dates stated and the charges are correct

DATE _____ AUTHORIZED OFFICIAL _____

AUDIT

This Claim is approved and ordered paid from the appropriations indicated above.