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		VOUCHER NO.
Total			
Check No.			

CLAIMANT'S NAME AND ADDRESS

TERMS _____

Vender's Ref. No. _____

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

CLAIMANT'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 Fire 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.

_____ _____

_____ _____

_____