

Agency Use Only		P.R. or Auth. No.
Agency No.	Location Code	
303	GR	

AGENCY NAME

Washington State Department of Health
DOH-CFH-CWP-WIC-NLS

VENDOR OR CLAIMANT

Social Security No. Or Tax ID.

INSTRUCTIONS TO VENDOR OR CLAIMANT:
Submit this form to claim payment for materials, merchandise or services. Show complete detail for each item.

Vendor's Certificate: I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for materials, merchandise or services furnished to the State of Washington, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, or Vietnam era or disabled veterans status.

By _____

(Title) (Date)

Received by: _____ Date Received: _____

I hereby certify that I attended the following:

- Core WIC New Nutritionist Orientation New Coordinator Orientation
Other _____

Dates Attended:

I therefore claim the following travel expenses:

# of Breakfasts _____	# of Lunches _____	# of Dinners _____
Meal Allowance \$ _____	Meal Allowance \$ _____	Meal Allowance \$ _____
Total: \$ _____	Total: \$ _____	Total: \$ _____

Meals:	\$ _____
Lodging: (attach original receipt)	\$ _____
Mileage: _____ X \$.505	\$ _____
Other: (describe clearly)	\$ _____
TOTAL:	\$ _____

Prepared by _____	Telephone Number (360) _____	Date _____	Agency Approval _____	Date _____
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Doc. Date _____	Pmt Due Date _____	Current Doc No. _____	Ref. Doc No. _____	Vendor Number _____	Vendor Message _____	Use Tax _____	UBI Number _____
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Fund	Appn Index	Master Index	Sub Obj	Sub Sub Obj	Org Index	WorkClass	County	City/Town	MOS	Project	Sub Proj	Proj Phas	Amount	Invoice Number
	752		EG	4112										

Accounting Approval for Payment _____	Date _____	Warrant Total _____	Warrant No. _____
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