



DEPARTMENTAL DEPOSIT FORM

| Index | Account# | Amount |
|--------------|-----------------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Total Amount of Deposit \$ _____ **Date** _____

Payer / Source of Funds _____

Did the Payer / Source of Funds receive all or part of this money from a federal agency?

Yes No (The Depositor is required to verify this information with the Payer.)

Depositor's Name _____

Comment _____

Reimbursement of Expenditures



Please return receipt to:

Name _____

Department _____

Phone _____