

# **CAVE CREEK / CAREFREE CHECK REQUISITION**

DATE: \_\_\_\_\_ TEAM NAME: \_\_\_\_\_

PAYABLE TO: \_\_\_\_\_ AMOUNT: \_\_\_\_\_

EXPENSE DETAILS: \_\_\_\_\_

REQUESTED BY: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Original receipts must be submitted for all amounts. Please attach receipts to this form

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CCCF BOARD AUTHORIZED BY: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

ASSOCIATION APPROVED: \_\_\_\_\_

AMOUNT PAID OUT: \_\_\_\_\_

CHECK NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_

Please retain this form for CCCF record keeping