ST. FRANCIS UNIVERSITY COLLEGE OF HEALTH & ALLIED SCIENCES

EXPENDITURE CLAIM FORM/PETTY CASH REQUISITION FORM

Name of applicant; _____

Designation: _____

Department:_____

Purpose: _____

Signature of Applicant_____ Date _____

Activity Code	Particulars	Qty/Trips	Rate	Amount
Total Request				

Amount in words:

_____

Applicant has/does not have unretired imprest of Tshs _____

Checked by:

HoD: _____Date: _____ Signature _____

Dean FoM/ Coordinator_____Date: _____ Signature _____

Verified by:

Accounts Office: : _____Date: _____Signature_____

Human Resources: _____Date: _____Signature_____

Approved by DP-ARC _____Date: _____Signature: _____

Authorized by DPPFA_____Date _____Signature_____