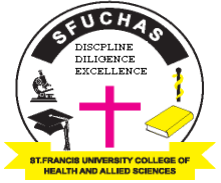




ST. FRANCIS UNIVERSITY COLLEGE OF HEALTH & ALLIED SCIENCES



EXPENDITURE CLAIM FORM/PETTY CASH REQUISITION FORM

Name of applicant; \_\_\_\_\_

Designation: \_\_\_\_\_

Department: \_\_\_\_\_

Purpose: \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Table with 5 columns: Activity Code, Particulars, Qty/Trips, Rate, Amount. Includes a Total Request row at the bottom.

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 \_\_\_\_\_