JOHNS HOPKINS HEALTH SYSTEM
CHECK REQUEST FORM

Please check appropriate affiliate:

Code		Affiliate	Code		Affiliate
0101	☐	JH HOSPITAL	0170	☐	INTRASTAFF
0122	☐	JH MEDICAL SERVICES CORP	0173	☐	SUBURBAN HEALTH CENTER
0130	☐	JH BAYVIEW MEDICAL CENTER	0174	☐	BROADWAY MEDICAL MANAGEMENT CORP
0131	☐	JH BAYVIEW GRANTS	0181	☐	OPHTHALMOLOGY ASSOCIATES
0135	☐	JH GERIATRICS CENTER	0182	☐	JH HEALTHCARE, LLC
0137	☐	JH BAYVIEW "D" BUILDING	01__	☐	______
0160	☐	JH HEALTH SYSTEM	01__	☐	______

Payable to: ______

Payee Address: ______

______

______

1099 Vendors MUST supply complete mailing address

Please check all appropriate boxes:

1099 Vendor Information

☐ 1099 Vendor. Request for 1st payment MUST be accompanied by contract.

☐ Soc Sec #/Fed. I.D. (1099) ______

☐ Attachments must be enclosed with check. Requestor must include original and photocopy of attachments.

Charge to:

Corp		Cost Center	Account	Amount
___	-0 0	_____	________	$ ______
___	-0 0	_____	________	$ ______
___	-0 0	_____	________	$ ______
___	-0 0	_____	________	$ ______
___	-0 0	_____	________	$ ______

Reason: ______

______

______

______

Request Prepared By: Name ______ Extension ______

Date: / / **Amount:** $ ______

Signature: ______

Date to be Paid: / /

APPROVALS

Department Approval: Name Extension

Department Head: ______ ______

Date / /

Functional Unit/Site/Admin:

Authorized Signature: ______ ______

Date / /

Finance Approval:

Authorized Signature: ______