

INVOICE REQUEST FORM

Billing information:

Contact Person: _____

Department: _____

District and High School: _____

ASL Instructor: _____

Address: _____

City, State, Zip: _____

Telephone number: _____

Fax number: _____

Email Address: _____

Purpose of invoice: Annual fee for SCCC ASL Consortium membership

\$ Amount: \$500.00

College Information:

Budget Number: 145-111-2N57

Department requested: ASL Consortium Program

Contact Person: Barbara Hayes

Telephone Number: 206.289.0820

Fax Number: 206.587.6337

If this is a prepaid invoice, in addition, please complete this section and attach the check with request form:

Check #: _____

Amount paid: _____

Date of check: _____