STATE OF NEW JERSEY

PAYMENT VOUCHER

(VENDOR INVOICE)

DOCUMENT			BATCH			ACTG PER	FY
TC	AGY	NUMBER	TC	AGY	NUMBER		

PO#	PV DATE	PP START			SCHED PAY			CHK CAT	OFF LIAB	F A	RF TY	CK FL	(A) VENDOR ID NUMBER
		MO	DY	YR	MO	DY	YR						

CONTRACT NO.	AGENCY REF	BUYER	(B) TERMS	PAYEE: SEE INSTRUCTIONS FOR COMPLETING ITEMS (A) THROUGH (G)	(C) TOTAL AMOUNT

(D) PAYEE NAME AND ADDRESS

(D) SEND COMPLETED FORM TO:

New Jersey Department of Health
Office of Emergency Medical Services
PO Box 360
Trenton, NJ 08625-0360

(F) PAYEE DECLARATIONS

I CERTIFY THAT THE WITHIN PAYMENT VOUCHER IS CORRECT IN ALL ITS PARTICULARS, THAT THE DESCRIBED GOODS OR SERVICES HAVE BEEN FURNISHED OR RENDERED AND THAT NO BONUS HAS BEEN GIVEN OR RECEIVED ON ACCOUNT OF SAID DOCUMENT.

➔➔➔➔ _____
PAYEE SIGNATURE

_____ PAYEE TITLE

_____ BILLING DATE

REEERENCE			LINE	(G) PAYEE REFERENCE
CD	AGY	NUMBER		
RA	**046**	**4220**	**01**	**COURSE NUMBER**

FUND	AGCY	ORG CODE	SUB-ORG	APPR UNIT	ACTIVITY CD	OBJECT CD	SUB-OBJ	REV SRCE	SUB-REV	PROJ/JOB NO
783	**046**	**4L06**		**001**	**J002**	**3890**				

RPT CT	BS ACT	DT	DESCRIPTION	QUANTITY	AMOUNT	ID	PF	TX

ITEM NO.	COMMODITY CODE/DESCRIPTION OF ITEM	QUANTITY	CREDITS	UNIT PRICE	AMOUNT
1	To reimburse the agency from the EMT Training Fund for the eligible volunteer student in Basic Courses # _____ This is the midcourse/end-of-course payments.				
				TOTAL	

CERTIFICATION BY RECEIVING AGENCY: I certify that the above articles have been received or services rendered as stated herein.

. . . . . .
Signature

. . . . . .
Title

. . . . . .
Date

CERTIFICATION BY APPROVAL OFFICER: I certify that this Payment Voucher is correct and just, and payment is approved.

. . . . . .
Authorized Signature

. . . . . .
Title

. . . . . .
Date