

INVOICE NUMBER _____

REIMBURSEMENT STATEMENT

TO: Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South DCEED/TB/A3
Denver, CO 80246

FROM: _____

FAX: (303) 691.7749

FEDERAL ID
NUMBER: _____

TYPE OF
PROGRAM: Tuberculosis Control Program

DATE OF EXPENDITURE: _____

FROM: _____

TO: _____

Final Bill? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Description of Expenditure	Requested Reimbursement Amount
TB Control	
Personal Services	
Fringe	
Supplies	
Equipment	
Travel	
Other (please specify)	
Indirect	
Directly-Observed Therapy	
Diagnostic Services	
GRAND TOTAL	

This is to certify that the above expenses were incurred per Contract # _____ and we are requesting reimbursement for the same.

SIGNATURE (CONTRACTOR): _____

DATE: _____

I hereby certify that all contract requirements have been met and the amounts are correct. Payment is authorized.

AUTHORIZED DESIGNEE (STATE): _____

DATE: _____

Contractor Notified of Reimbursement Amount change? <input type="checkbox"/> Yes <input type="checkbox"/> No Initial: _____
