

Berlin Central School District

P.O. Box 259 – Berlin, NY 12022
 Telephone: (518) 658-2684 - Fax: (518) 658-3822

CLAIM FORM

Name: _____ Date: ____/____/____

Address: _____

Independent contractors must have a W-9 Form on file before payment will be made.

Type of service provided (if applicable): _____

All charges below must have receipts (if applicable) attached for verification. With the exception of meal claims, the school district is not permitted to reimburse for New York State Sales Tax.

Submit claim form to supervisor for approval.

Date	Description	Budget Code	Amount
		Total	\$

I certify that the materials and/or services included in this claim have been actually performed for, furnished and/or delivered to the Berlin Central School District.

Claimant Signature: _____ Date: ____/____/____

I certify that this claim has been rendered in accordance with the contract, agreement, accepted estimate, or policies in effect, and that the claim has been verified as true and correct.

Supervisor Approval: _____ Date: ____/____/____

Purchasing Agent: _____ Date: ____/____/____