

# SALISBURY UNIVERSITY

## REIMBURSEMENT REQUEST

|                                  |  |
|----------------------------------|--|
| <b>Vendor Name:</b>              |  |
| <b>Vendor Address, line 1:</b>   |  |
| <b>SS Number or EIN:</b>         |  |
| <b>Vendor Address, line 2:</b>   |  |
| <b>City, State and Zip Code:</b> |  |
| <b>Vendor Email Address:</b>     |  |
| <b>Vendor Telephone #:</b>       |  |

**Reason for reimbursement:**

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**Reimbursement Amount:** \$ \_\_\_\_\_ . \_\_\_\_\_

**USource(s) to be charged:** \_\_\_\_\_

**Spend Category to be charged:** \_\_\_\_\_

**USource Manager/PI Printed Name & Signature:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

*Upload completed form in WorkDay as a backup document for the Supplier Invoice Request.*