

POLAND CSD CLAIM FORM

74 Cold Brook Street, Poland, New York 13431
Telephone: (315) 826-0205 Fax: (315) 826-7516

TO BE COMPLETED BY PERSON MAKING CLAIM

Name of Person Making Claim: _____

Address of Person Making Claim: _____

Social Security Number for any person whose number is not on file: _____

Quantity	Description and/or time and date of activity.	Hourly Rate	To Pay

I hereby certify that the work, labor, services, materials, and supplies charged in the above account or claim have been actually performed and/or delivered to the Poland Central School District, and, that said claim is just and unpaid.

FORM TOTAL

Claimant's Name	Signature	Title	Date

THIS SECTION FOR OFFICE USE ONLY

Approval of the Officer Giving Rise to Claim

I hereby certify that this bill has been rendered in accordance with the contract, agreement, or accepted estimate, and that the work has been completed and the materials delivered satisfactorily.

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School Employee Who Affirms the
Above Statement

Date

Signature of Purchasing Agent

Date