

**SOUTH CAROLINA SOCIETY OF MEDICAL ASSISTANTS, INC.**

**VOUCHER FOR 3/31/2021 TO 3/31/2022**

**Date of Purchase/Expenditure** \_\_\_\_\_

**Name of Purchaser/Committee:** \_\_\_\_\_

**Item of Purchase/Expenditure:** \_\_\_\_\_

**Amount spent:** \_\_\_\_\_

**Committee Account Number** \_\_\_\_\_

**Reason for Purchase**

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**Pay to the order of: (print name and address and attach paid receipt or original invoice if paying to vendor)**

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**Date of reimbursement/payment:** \_\_\_\_\_

**Check number** \_\_\_\_\_

**Signature of State Treasurer**

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Starr, SC 29684  
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