SOUTH CAROLINA SOCIETY OF MEDICAL ASSISTANTS, INC.

VOUCHER FOR 3/31/2023 TO 3/31/2024

Date of Purchase/Expenditure____

Name of Purchaser/Committee: ____

Item of Purchase/Expenditure: ____

Amount spent: ______________________________

Committee Account Number___________________

Reason for Purchase

____

____

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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Goose Creek, SC 29445
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