

SOUTH CAROLINA SOCIETY OF MEDICAL ASSISTANTS, INC.

VOUCHER FOR 3/15/2026 TO 03/15/2027

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)

Date of reimbursement/payment: _____

Check number _____

Signature of State Treasurer

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