



Staff Initiated Funding Disbursement of Funds

Item Approved : _____ Amount Approved: _____

Date Approved: _____

Names/ vendor as it should appear on check:

Mailing Address: _____

E-mail: _____ Telephone: _____

Tax ID# or Social Security #: _____
(If not an employee of the school)

If matching funds were a condition of the disbursement of these funds, when and by whom were the matching funds approved?

Please include all bills or receipts.

These funds must be drawn within six months of your funding request approval or by July 1st, whichever comes first.

FONPS office use only

Date _____

Check _____

Amount _____

*Please submit this form, along with any bills or receipts, to the FONPS office, at NHS/Room 001,
10 Surfside Road, Nantucket, MA 02554 (508)228-7285 ext. 1168*