SOUTH CAROLINA SOCIETY OF MEDICAL ASSISTANTS, INC.

VOUCHER FOR 3/31/2024 TO 3/31/2025

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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Goose Creek, SC 29445
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