| CLAIMS PAYMENT REQUEST | | | | | | | |
|---|--|--|--|---|---------------------|--|----------|
| FROM: Orcas Island Health Care District | Fund# 6541.00 | 541.00 | | | | | |
| Date: 7/9/2018 | | | | | P | Page 1 of | |
| Invoice # Description | Inv. Date Ve | Vendor# | Vendor Name | Amount Gra | Grant /Level Bars # | ars# | 1099 |
| Superintendent Ad | | ska144 Skagit Publishing | blishing | 101 | 65 | 6541.00.561.00.41.0060 | |
| 814482 Start up legal work | 6/13 sou | sou100 Sound Publishing | ablishing | 77.07 | 65 | 6541.00.561.00.41.0060 | |
| See | 1, 10 | Cada | Ogasii mui priy vvaliace Awilisys | 4968.00 | 00 | 6541.00.561.00.41.0030 | |
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| | | | TOTAL THIS PAGE TOTAL BOTH PAGES | 5,620.37 | | | |
| I, the undersigned, do hereby certify under penalty of perjury that the materials have been furnished and payable pursuant to a contract or is available as an option for full or partial fulfillment of a contractity/county/district), and that I am authorized to authorized and certify to said claim. (city/county/district), and that I am authorized to authorized to authorized to authorized. | penalty of perjury th liable as an option for the definition of th | r that the materials on for full or partial pe and certify to sail the full of | I, the undersigned, do hereby certify under penalty of perjury that the materials have been furnished, the services rendered or the labor performed as described herein, that any advance payment is due and payable pursuant to a contract or is available as an option for full or partial fulfillment of a contractual obligation, and that the claim is a just, due and unpaid obligation against the (city/county/district), and that I am authorized to authepticate and certify to said claim. Signed Title () MMMSSIONUM SULVATIONALMANCE. | erformed as des a just, due and Title | unpaid oblig | s described herein, that any advance payment is due and unpaid obligation against the Title DMMSSIONULL SULLATION | s due |
| , the undersigned, do hereby certify under p | enalty of perjury tha | that the claim is a | I, the undersigned, do hereby certify under penalty of perjusy that the claim is a just, due and unpaid obligation against the Orcas Island Health Care District, and that I am authorized to certify to said claim Signed Title | alth Care Distric Title | ct, and that I | Title Apply Title Apply Title | d claim. |
| Board Authorization As the duly elected board for this district we for the period ending | have reviewed t We approve | e reviewed the claims listed above(including orig We approve payment with our signatures below | Board Authorization As the duly elected board for this district we have reviewed the claims listed above(including original backup materials) totaling for the period ending We approve payment with our signatures below. | | | | |
| Commissioner | Date | Commissioner | oner Date | te | | | |
| Commissioner | Date | Commissioner | oner Date | fe | | | |
| Commissioner | Date | | | | | | |
| Note: It is the DISTRICTS' responsib | ility to maintain | adequate, origina | Note: It is the DISTRICTS' responsibility to maintain adequate, original, records to substantiate these claims. | | | | |