



OFFICE USE ONLY	
Date Paid:	
Check #:	

Consolidated Missionary Baptist State Convention of Arkansas, Inc.

Mailing Address:
P.O. Box 34130
Little Rock, AR 72203

Requisition Form

Advance Payment Reimbursement

Auxiliary:	Today's Date:	Date Payment Needed:
Requestor's Name:	Address:	
Phone:	Email:	

Description	Quantity (if applicable)	Amount

Method of Payment: Check Debit/Credit Card

Payee: _____

Address (if mailed): _____

Approved By		
Department President/Date	CMBSC Treasurer/Date	CMBSC President/Date

Mileage Rate: \$.56/mile
Per Diem: \$41/day

Once approved, please allow 2 weeks for check to be written.

Revised 04/26/2019

Original invoice and/or receipts required for all requests.

Payment to a sole proprietor requires submission of W-9