ACH/WARRANT NO.

Reset Form

CLAIM AGAINST SIBLEY COUNTY, MINNESOTA

SIBLEY COUNTY

DATE CLAIM WILL BE PAID: ______________________

☐ Commissioner Claim ☐ Auditor Claim ☐ Library Claim

Vendor No.: ______________ Vendor: ______________________________

Address: ____

City: ______________________ State: __________ Zip Code: __________

Vendor Must Attach Invoice to the County Auditor, P.O. Box 171, Gaylord, MN 55334-0171

Account Code	Description	Invoice Number	Service Dates (if applicable)	On Behalf Of Vendor # (use only for P-card claim)	Amount
*Attach all invoices/receipts with paperclip and attach remittance to left side of claim. *Capital Equipment Purchases of $5,000 or more require prior County Board Approval. (P01042011)		**TOTAL AMOUNT OF THIS CLAIM**			

I declare, under penalties of law, that this account, claim or demand is just and correct, and that no part has been paid. (Pursuant to M.S. 471.38

X ______________________________

Claimant Signature

I hereby approve the payment of the above claim.

X ______________________________

Department Head Signature Date

Audited by: __________ ☐ Aud ☐ PHHS ☐ PW

Comments: