

SCHOOLS HEALTH INSURANCE FUND

9 Campus Drive suite 216
 Parsippany, NJ 07054

Pay To : _____

Address : _____

Taxpayer Identification # : _____ Purchase Order #: _____

NOTE: All Bills Must Be Properly Certified Before Payment

DATE	ITEMS	TOTAL
	TOTAL OF THIS BILLING	

Claimant's Certification and Declaration

I do solemnly declare and certify under the penalties of the law that the within bill is correct in all its particulars; that the articles have been furnished or services rendered as stated therein; that no bonus has been given or received by any person or persons with the knowledge of this claimant in connection with the above claim; that the amount stated therein is justly due and owing and that the amount charged is a reasonable one. I further certify that I am an Equal Opportunity Employer and that I have complied with the Affirmative Action regulations issued by the New Jersey Department of the Treasury.

Vendor's Signature _____ Title _____ Date _____

OFFICERS CERTIFICATION

I, having knowledge of the facts, certify that the materials and supplies have been received or the services rendered; this certification being based on signed delivery slips or other reasonable procedures.

Signature: _____

Title: _____

APPROPRIATIONS OR ACCOUNTS CHARGED	PAYMENT AUTHORIZED
	Payment approved at a meeting on
	Date