MARYLAND DEPARTMENT OF HEALTH
REGISTRATION PAYMENT REQUEST

TO: **Cash Receipts Section** **Date:** _____
Division of General Accounting
201 West Preston Street (Across from Room 537)
Baltimore MD 21201

FROM: **Fiscal Officer Approval:**

SUBJ: Registration Payment Request
****

Employee's Name: _____ **Phone Number:** _____

Date of Travel:_____/_____/_____ **Thru** _____/_____/_____

Location: _____

PCA Code: _____ **AGYOBJ/ITEM:** _____

Destination: _____ **Out of State Request #**_____

Purpose: _____

REGISTRATION INFORMATION

Deadline: _____/_____/_____

Amount: **$**_____

Make Check Payable To: _____

Mail Check To:

Name/ATTN: _____

Address: _____

City, State, Zip: _____

NOTE: ATTACH ORIGINAL APPLICATION FORM & ADDRESSED ENVELOPE.

Special Instructions:_____

_____

DHMH 4524

Revised 05/23