UNIVERSITY OF KANSAS MEDICAL CENTER
APPLICATION FOR AN SPECIAL SERVICES ACCOUNT

Date:

Number: **OB**
Begin Date:
End Date:

A. Account Information: (Title of Account)

(Department or Organization Name) (Dept. #)

B. Responsible Person: (Responsible Person's Name) (Phone #)

(Responsible Person's Title) (Fax #)

(Billing Address)

C. Justification: Please explain in detail why your organization is applying for a billing account And what type of items you will charge.

E. What source of funds will be used to pay for charges?

Account Number: Account Description:

F. Should Kansas sales tax be applied? Yes No

If no, explain why (Endowment Funded, Attached Exemption Certificate, etc.)

I do hereby certify that this Outside Billing Account will be used as provided by law and by regulations set out by the Director of Accounts & Reports of the State of Kansas, and I assume responsibility for the payment of all charges against this account.

Signature of Responsible Party	Date	Department/Agency Chair Approval	Date

Please submit completed application to:

University of Kansas Medical Ctr
Controller's Office
2100 W. 36th Street
120-E Support Services Facility
Kansas City, KS 66160-7103

Controller Approval	Date

8/22/05