

CO - 17 REV. 10/2010

VENDOR: PLEASE COMPLETE THIS FORM AND SEND IT TO THE
DEPARTMENT **BILLING ADDRESS** SHOWN ON THE PURCHASE ORDER.

(1) BUSINESS UNIT NAME ADS/LTCOP		(2) BUSINESS UNIT NO.		(3) INVOICE NO.		(4) INVOICE AMOUNT			
(5) DOCUMENT DATE / /		(6) INVOICE DATE		(7) ACCOUNTING DATE		(8) RPT. TYPE		(9) VENDOR FEIN/SSN ID / ADDRESS CODE	

(10)		(11) VOUCHER NO.
PAYEE:		
PAYEE:		
ADDRESS:		(12) VOUCHER DATE
ADDRESS:		
ADDRESS:		PREPARED BY
CITY: TOWN	STATE : CT	COUNTRY: US
		ZIP CODE : ZIP

(14) GIVE FULL DESCRIPTION OF GOODS AND / OR SERVICES (TO BE COMPLETED BY VENDOR)	(15) QUANTITY	(16) UNITS	(17) UNIT PRICE	(18) AMOUNT
			.76	
VRA Signature: _____ DATE_____ RO Signature: _____			TOTAL	

[illegible]

(30) DEPARTMENT NAME AND ADDRESS Department on Aging and Disability Services 55 Farmington Ave, 12th Floor Hartford, CT 06105	(31) PO NO.	(32) COMMODITIES RECEIVED OR SERVICES RENDERED - SIGNATURE	
	(33) PO BUSINESS UNIT	(34) RECEIVING REPORT NO.	(35) DATE(S) OF RECEIPT(S)

(36) DATE SHIPPED	(37) FROM - CITY / STATE	(38) VIA - CARRIER	(39) F.O.B.
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