Form
A19-1A

STATE OF WASHINGTON
INVOICE VOUCHER

AGENCY USE ONLY		REVISED MAY 2009
AGENCY NO.	LOCATION CODE	PR OR AUTHOR. NO.
3000	EB1	RCW 70.58.080

AGENCY NAME

DSHS/ESA/OS Fiscal
Division of Child Support Fiscal Unit
PO Box 45445
Olympia WA 98504-5445

HOSPITAL/BUSINESS (Warrant is to be payable to)

INVOICE NUMBER: _____ DATE: _____

INSTRUCTIONS TO VENDOR OR CLAIMANT: Submit this form to obtain payment for materials, merchandise or services. Show complete detail for each item.

VENDOR'S CERTIFICATE: ***I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for materials, merchandise or services furnished to the State of Washington, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, or Vietnam era or disabled veterans status.***

BY: (SIGN IN INK)

PHONE NUMBER DATE

DATE OF BIRTH	CHILD'S FULL NAME		DATE OF BIRTH	CHILD'S FULL NAME

TOTAL QUANTITY FOR PAYMENT: _____ X $20.00 = $_____ (Total Due)

CURRENT DOC NUMBER	VENDOR NUMBER	AGENCY APPROVAL	DATE

	TRANS CODE	FUND	APPN INDEX	PROGRAM INDEX	SUB OBJ	SUB OBJ	ORG INDEX	ALLOC	MOS	AMOUNT	INVOICE NUMBER
		001			**ER**	**9478**	**M7A0**	**9999**			

ACCOUNTING APPROVAL FOR PAYMENT	DATE	WARRANT TOTAL	