# State Aid Voucher Form

## State of New York

### Originating Agency

**NYS Department of Health**

### Payment Date

(MON) / (DD) (YY)

### OSC Use Only

Liability Date (MON) (DD) (YY)

### Payee ID

14-1368361

### Additional Zip Code

12201-0009

### Payee Name

THE RESEARCH FOUNDATION OF

### State University of New York

PO Box 9

### Address

55104 / 1208536

### Ref/Inv. No.

(MON) (DD) (YY)

### Ref/Inv. Date

(MON) (DD) (YY)

### Address

Address Limit to 30 Spacing

### City

ALBANY NY 12201-0009

### Zip Code

100013735

### Vendor Identification Number

MAR / 26 / 12

### Date

11-MAY-2012

### Description of Charges

REQUESTED REIMBURSEMENT FOR THE PERIOD:

01-DEC-11 - 29-FEB-12

### Amount

$76,571 55

### State Aid Program or Applicable Statute:

I certify that the above expenditures have been made in accordance with the provisions of the Applicable Statute, that the claim is just and correct, that no part thereof has been paid except as stated, that the balance is actually due and owing, and that taxes which the State is exempt from are excluded.

### Title

AR/REPORTING COORDINATOR

### Name of Municipality

THE RESEARCH FOUNDATION OF SUNY

### For Agency Use Only

### State Comptroller's Pre-Audit

### Merchandise Received

I certify that this voucher is correct and just, and payment is approved.

### State Aid

Certified For Payment of State Aid Amount

### Verified

By

### Audited

By Date

### Expenditure

<table>
<thead>
<tr>
<th>Cost Center Code</th>
<th>Object</th>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dept.</td>
<td>Cost Center Unit</td>
<td>Var Yr</td>
<td>Amount</td>
</tr>
</tbody>
</table>

### Liquidation

- □ Check if Continuation form is attached.