

TEXAS TECH UNIVERSITY
TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
REQUEST FOR INTERDEPARTMENTAL COST TRANSFER

CREDIT INFORMATION:

ACCOUNT NUMBER: _____
Fund Area Orgn
_____ Object Sub-Object Amount

ACCOUNT NAME: _____

Approved: _____
Account Manager

CHARGE INFORMATION:

ACCOUNT NUMBER: _____
Fund Area Orgn
_____ Object Sub-Object Amount

ACCOUNT NAME: _____

Approved: _____
Account Manager

ORIGINAL DOCUMENT NUMBER: _____

DATE OF ORIGINAL DOCUMENT (if known): _____

THE DOLLAR AMOUNT OF THIS TRANSFER IS (check one):

ALL
 PART OF THE DOLLAR AMOUNT OF THE ORIGINAL DOCUMENT NUMBER

REASON FOR TRANSFER: _____

Approved: _____
Accounting Services

PREPARED BY: _____ DATE: _____

DEPARTMENT: _____ PHONE NUMBER: _____

CAMPUS ADDRESS: _____ MAILSTOP: _____