Medical College of Georgia

Authorized Signature Form for Departments

Department:		**Contact:**
Effective Date:	**Bldg./Rm#:**	**Phone #:**

Department ID	**Print Name of Authorized Signature**	**Authorized Employee Signature(s)**

Department Manager Printed Name	**Department Manager Signature(s)**	**Title**	**Date**

*** All authorized signature additions or deletions must be approved by the Department Head.**

Once approved, return completed form to: Controller's Division, Financial Accounting, HS B107

Note: Only one Department ID per form.

For Internal Use Only: Copies to Travel _____, Purchasing _____, Cashiers _____; Date Completed: _____

Revised 01/06