



THE UNIVERSITY of NORTH TEXAS
HEALTH SCIENCE CENTER at FORT WORTH

Deposit Form

Department Name: _____ Date _____

Item Description	GL Bus. Unit	Account	Org. Dept.	Fund Category	Fund	Function*	Project*	Program*	Purpose*	Site*	Amount
										TOTAL	

* Indicates field is conditional and may not apply to every transaction.

Currency (by dollar amount)

\$100.00 _____
 \$50.00 _____
 \$20.00 _____
 \$10.00 _____
 \$5.00 _____
 \$2.00 _____
 \$1.00 _____

Total:

Coins

\$1.00 _____
 \$0.50 _____
 \$0.25 _____
 \$0.10 _____
 \$0.05 _____
 \$0.01 _____
 Total

Amount

Cash**	_____	Enter# of checks below
Checks**	_____	
Grand Total	_____	

Please provide a contact phone number below (Phone Ext.) for any questions the Cashier's Office may have regarding this deposit. By signing below, I certify that the above deposit has been examined and verified.

 Prepared By (PRINT) Phone Ext Signature

 Verified By (PRINT) Phone Ext Signature

Distribution:

Cashier's will keep this copy.
 Bring extras for departmental records if needed.

****10-KEY TAPE OR SPREADSHEET LISTING OF CASH AND CHECKS MUST BE ATTACHED**

Cashier Use ONLY

Received By (not processed)	_____
Date Received	_____
Date Processed	_____
Cashier	_____
Receipt #	_____