|  |  |
| --- | --- |
| Description: SDDH Main Logo CMYK State of South Dakota Department of Health Attn: West Nile Grant Program 600 E Capitol Ave Pierre, SD 57501 (605)773-8107 Or Email to: Julie.Ramsey@state.sd.us  | Date Submitted: |

Recipient

|  |  |
| --- | --- |
|  | (your information below) |
| **City/County/Tribe:** |  |
| **Attention:** |  |
| **Mailing Address:** |  |
| **City:** |  |
| **State:** |  |
| **Zip:** |  |
| **Daytime Phone:** |  |

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| --- | --- | --- |
| **Date** | **Description of Expenses**(Chemical/Equipment)Proof of Purchase must be attached | **Total** |
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|  |  |  |
|  |  |  |
|  | **Description of Wages**(must include employee name, hours worked, and rate of pay) |  |
|  | Name: | Hours Worked: | Rate of Pay: |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
| **TOTAL** |  |

**Recipient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**