|  |  |
| --- | --- |
| 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](mailto:Julie.Ramsey@state.sd.us) | Date Submitted: |

Recipient

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**