

REQUEST FOR REIMBURSEMENT (RFR) FORM

Amount paid by Sponsor to date: S	RFR (Sequence) #:	Date:
Project Name: Final RFR? (Y or N) AIP Grant #: Amount of AIP Grant (if applicable): Amount of SCAC Grant: \$ Amount billed to Sponsor to date: \$ Amount previously billed to State: \$ Amount previously billed to State: \$ Amount of payment requested this RFR: \$ This is to certify that the required local funds, a minimum of \$	SCAC Grant / Project #:	Airport ID:
Amount of AIP Grant (if applicable): Amount of SCAC Grant: Amount billed to Sponsor to date: Amount paid by Sponsor to date: Amount previously billed to State: Spansount previously billed to State: Amount of payment requested this RFR: Spansount of the Sound Carolina Aeronautics Commission (SCAC) for this project; and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no other State funds will be used to match had and no nother State funds will be used to match had and no nother State funds will be used to match had and no nother State funds will be used to match had and nother State funds will be used to match had and nother State funds will be used to match had and nother State funds will be used to match had and nother State funds will be used to match had and nother State funds will be used to match had nother State funds will be used to match had nother State funds will be used to match had noth	Airport Name:	
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Fotal previously reimbursed: Amount of this request: Unpaid balance remaining: Audited by: Date approved for payment:	For Aeronautics Staff use only:	
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Unpaid balance remaining: \$ Audited by: Date approved for payment:	Total previously reimbursed:	\$
Audited by: Date approved for payment:	Amount of this request:	\$
Date approved for payment:	Unpaid balance remaining:	\$
	Audited by:	
Account ID #:	Date approved for payment:	
Account to #.	Account ID #:	