JULY 1, 2003 PACKAGE

COST DOCUMENTATION

SUBMITTED BY ATSDR

ATSDR TRANSMITTAL LETTERS DATED
MAY 5, 2003 AND JULY 1, 2003

DOCUMENTATION PROVIDED:

IAG NUMBER		ATSDR DOC	AMOUNT
HEALTH ASSESSMENT	*	REPORT I	$0.00
DW75784001	**	REPORT II	$95,238.00
DW75868001	**	REPORT III	$483,972.38
DW75950377	**	REPORT IV	$14,286.00

* THE COST OF HEALTH ASSESSMENTS ARE NOT REIMBURSED BY EPA TO ATSDR. EPA INCLUDES THE COST OF HEALTH ASSESSMENTS ON BEHALF OF ATSDR FOR COST RECOVERY. THESE COSTS DO NOT APPEAR IN EPA'S COST REPORTS.

** ATSDR COST UNDER THESE IAGS IS REIMBURSED TO ATSDR BY EPA. THESE COSTS ARE INCLUDED IN EPA'S COST REPORTS.

COST CLAIMED ON 5-5-03 LETTER

DOCUMENTATION PROVIDED WITH 7-1-03 LETTER

989627

ATSDR COST DOCUMENTED AND CLAIMED IN THIS COST PACKAGE

TAR CREEK OP UNIT 2 06-BE ATSDR COST DOCUMENTATION

	ATSDR COST DOC					
	INCEP TO 3-31-02		4-1-02 TO 3-31-03	4-1-03 TO 6-30-03 (insig cost after 5-31)		
	ATSDR TRANSMITTAL LETTERS:					
AGREEMENTS	DTD 8-28-02	DTD 5-5-03	DTD 8-21-03	DTD 9-25-03	DOCUMENTED AMOUNT	CLAIMED AMOUNT
ATSDR HEALTH ASSESS	Note 1 & 2		$53,913.09	$14,758.86	$68,671.95	$68,671.95
ATSDR SITE-SPECIFIC IAGs : Note 3 ATSDR COST DOCUMENTATION:					DOCUMENTED AMOUNTS	CLAIMED AMOUNTS Note 4
DW75784001 - ATSDR		$95,238.00			$95,238.00	$94,917.99
DW75868001 - ATSDR		$483,972.38	$116,027.62		$600,000.00	$600,000.00
DW75950377 - ATSDR		$14,286.00	$172,426.56	$42,535.64	$229,248.20	$23,810.00
TOTAL IAGs		$593,496.38	$288,454.18	$42,535.64	$924,486.20 (see next page)	$718,727.99
ADD EPA INDIRECT COST						$292,693.70
						$1,011,421.69

Note 1 THE COST OF HEALTH ASSESSMENTS ARE NOT REIMBURSED BY EPA TO ATSDR. EPA INCLUDES THIS E COST ON BEHALF OF ATSDR FOR COST RECOVERY THESE COSTS DO NOT APPEAR IN EPA COST REPORTS. EPA INDIRECT COST IS NOT APPLICABLE TO THIS COST.

Note 2 ATSDR COST OF $203,190.82 WAS DOCUMENTED IN OUR PRIOR COST PACKAGE FOR THE PERIOD THRU 3-31-2002.

Note 3 THESE COSTS ARE REIMBURSED TO ATSDR BY EPA. THESE COSTS ARE INCLUDED IN EPA'S COST REPORTS. EPA INDIRECT COST IS APPLICABLE TO THIS

Note 4 DUE TO BILLING LAG TIME, ATSDR REPORTED COSTS EXCEED THE AMOUNTS BILLED TO EPA. AT THIS TIME, WE ARE CLAIMING THE LESSER AMOUNT.

CROSS-REFERENCE TO ATSDR COST DOCUMENTATION

ATSDR COST DOCUMENTATION IS LOCATED BY REPORT NUMBER WITHIN THE ATSDR COST PACKAGES

TAR CREEK OP UNIT 2 06-BE

	-----Previously Reported----		----------Current Cost Package---------- THREE SEPARATE SUBMISSIONS BY ATSDR						
	ATSDR COST PKG ----------DTD 8-28-02--------- INCEP TO 3-31-02		ATSDR COST PKG ----------DTD 5-5-03--------- INCEP TO 3-31-02		ATSDR COST PKG ----------DTD 8-21-03------ 4-1-02 TO 3-31-03		ATSDR COST PKG ----------DTD 9-25-03------ 4-1-03 TO 6-30-03		
	AMOUNT	REPORT	AMOUNT	REPORT	AMOUNT	REPORT	AMOUNT	REPORT	TOTAL
Region 6 - ATSDR Site-Specific IAGs (Blood Lead Testing/Education)									TOTAL Before EPA Indirect Cost
DW75784001			$95,238.00	REPT II					$95,238.00
DW75868001			$483,972.38	REPT III	$116,027.62	REPT II			$600,000.00
DW75950377			$14,286.00	REPT IV	$172,426.56	REPT III	$42,535.64	REPT II	$229,248.20
TOTAL IAGs			$593,496.38		$288,454.18		$42,535.64		$924,486.20
ATSDR Cost									
(Health Assessments)									
Previously Reported	$203,190.82	NO REPT #							$203,190.82
Current Cost Package			$0.00	REPT I	$53,913.09	REPT I	$14,758.86	REPT I	$68,671.95
									$271,862.77

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Agency for Toxic Substances
and Disease Registry
Atlanta GA 30333

JUL 01 2003

Mr. Dennis McBride
U.S. EPA - Region 6
Accounting Section (6MD-RS)
1445 Ross Avenue, Suite 1200
Dallas, Texas 75202-2733

Dear Mr. McBride:

Enclosed is supplemental documentation for the **Tar Creek (Ottawa County) (OU2), Ottawa County, Oklahoma, (60BE), CERCLIS No. OKD980629844** Superfund site for costs incurred through the period ending March 31, 2002. This documentation was provided by the Oklahoma State Department of Health, Financial Management Service, to support costs incurred through cooperative agreements with the Agency for Toxic Substances and Disease Registry (ATSDR). Funds for these cooperative agreements were provided to the ATSDR under several site-specific Interagency Agreements (IAGs) through which the Environmental Protection Agency (EPA) funded work at the Tar Creek Superfund site. EPA has requested that the ATSDR separately report costs associated with these IAGs.

Please note that the IAG costs reported by the ATSDR in the previous cost package dated May 5, 2003, Cost Summary Reports II, III and IV, were limited to:

- Cooperative agreement disbursements reported by Oklahoma in their 272 Quarterly Reports to the Health and Human Services (HHS), Division of Payment Management (DPM), Payment Management System (PMS) through the period ending March 31, 2002, and
- Amounts retained by the Centers for Disease Control and Prevention (CDC) for administrative support services provided to ATSDR for these IAGs.

Therefore, previously reported cooperative agreement costs are less than amounts included by Oklahoma in their supplemental documentation. Please ensure that the costs reported in our package dated May 5, 2003, are not duplicated in EPA's financial accounting system as billings under the IAGs.

As you requested, we have only provided a redacted copy of this information. ATSDR has ongoing responsibilities at active Superfund sites. Consequently, additional costs will be incurred in the future.

Please contact me or Richard Haj at (404) 498-0050 if you have questions concerning this cost recovery matter.

Sincerely yours,

Betty N. Jones
Cost Recovery Team Leader

Enclosures
cc:
Mark S. Kashdan, CDC/ATSDR, OGC
George Pettigrew, ATSDR, ORO

THE AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

Cost Summary

Supplemental documentation through March 31, 2002

for

TAR CREEK (OTTAWA COUNTY) (OU2)
Ottawa County, Oklahoma
CERCLIS No. OKD980629844
(60BE)

Date prepared: June 30, 2003

Narrative Cost Summary Report:

1. The Agency for Toxic Substances and Disease Registry (ATSDR) has included a Summary of Interagency Agreements (IAGs) with the Environmental Protection Agency (EPA) for this site and information printed from the Health and Human Services (HHS), The Division of Payment Management (DPM), Payment Management System (PMS) internet site http://www.dpm.psc.gov.

Payment of cooperative agreement funds to the Oklahoma State Department of Health were made available through the PMS.

Oklahoma State Department of Health costs reported by ATSDR in Reports II and III of the previous cost package dated May 5, 2003, were limited to cooperative agreement amounts in the PMS system.

2. The Agency for Toxic Substances and Disease Registry (ATSDR) has included cost recovery documentation provided by the Oklahoma State Department of Health under a cooperative agreement during the period September 29, 1998, through March 31, 2002.

Summary of ATSDR's costs for site 60BE submitted to EPA Region VI:

$	203,190.82	Costs provided in our letter dated August 28, 2002
	0.00	Additional costs included in Report I of our letter dated May 5, 2003
	95,238.00	Additional costs included in Report II of our letter dated May 5, 2003
	483,972.38	Additional costs included in Report III of our letter dated May 5, 2003
	14,286.00	Additional costs included in Report IV of our letter dated May 5, 2003
	0.00	Supplemental cost documentation included in this update
$	796,687.20	Total costs provided to date

PERSONAL IDENTIFIER(S) REDACTED

SUMMARY OF IAGS WITH EPA

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY
Costs for the period through March 31, 2002
for
Tar Creek (Ottawa County)
Ottawa County, Oklahoma
(60BE)

REIMBURSABLE INTERAGENCY AGREEMENTS WITH ENVIRONMENTAL PROTECTION AGENCY

1	EPA/IAG Identification Number: DW-75-937840-01-3	Increase: Augment	See Schedule 1 for Additional Information *
2a	EPA/IAG Identification Number: DW-75-938680-01-0	New Project	See Schedule 2 for Additional Information *
2b	EPA/IAG Identification Number: DW-75-938680-01-1	Augmentation: Increase	See Schedule 3 for Additional Information *
3	EPA/IAG Identification Number: DW-75-950377-01-0	New	See Schedule 4 for Additional Information *

(* Reference to information in May 5, 2003 cost package)

1	Funding Amount:	ATSDR Id #		Direct		Indirect (Notes 1& 2)		Total
	Tar Creek (Announcement # 98064 - New Amount)	**ATSDR-98-0002-02 (AT97-006)**	**$**	**95,238.00**	**$**	**4,762.00**	**$**	**100,000.00**
	Methyl Parathion-NORC & MRI		$	952,381.00	$	47,619.00	$	1,000,000.00
	NACCHO		$	71,429.00	$	3,571.00	$	75,000.00
			$	1,119,048.00	$	55,952.00	$	1,175,000.00

2a	Funding Amount:	ATSDR Id #		Direct		Indirect (Note 1)		Total
	Tar Creek	**AT99-006**	**$**	**285,714.00**	**$**	**14,286.00**	**$**	**300,000.00**
	East Texas Area Health Education Centers (AHEC)	AT98-014	$	33,333.00	$	1,667.00	$	35,000.00
			$	319,047.00	$	15,953.00	$	335,000.00

2b	Funding Amount:	ATSDR Id #		Direct		Indirect (Note 1)		Total
	Tar Creek	**AT99-006**	**$**	**285,714.00**	**$**	**14,286.00**	**$**	**300,000.00**
			$	285,714.00	$	14,286.00	$	300,000.00

3	Funding Amount:	ATSDR Id #		Direct		Indirect (Note 1)		Total
	Tar Creek	**AT99-006**	**$**	**285,714.00**	**$**	**14,286.00**	**$**	**300,000.00**
			$	285,714.00	$	14,286.00	$	300,000.00

(Note 1): Amount retained by Centers for Disease Control and Prevention (CDC) for administrative support services provided to ATSDR for this IAG. CDC used common account number (CAN) 921T049 for its indirect costs.
CDC provides administrative support services to ATSDR under an interagency agreement. This support includes all processing of ATSDR's financial data. CDC's financial management system is called the Total Online Processing System (TOPS).
(Note 2): Must obtain additional information from CDC to confirm payment of Indirect Costs associated with this IAG

Funds provided to ATSDR by EPA were disbursed to the Oklahoma State Department of Health through Cooperative Agreements.

Payment of Cooperative Agreement funds to the Oklahoma State Department of Health were made available through the Department of Health and Human Services (HHS) Payment Management System (PMS). PMS is administered by the Division of Payment Management, Program Support Center HHS, Rockville, Maryland.

REIMBURSABLE INTERAGENCY AGREEMENTS

Quarterly reports of cash expenditures by award recipient are required by PMS. PMS then electronically submits this information to CDC's TOPS accounting system. On behalf of ATSDR, CDC periodically bills EPA for reimbursement.

	Oklahoma State DOH's PMS/Quarterly Report of Cash Expenditures (per PMS Inquiry)	PMS reports to CDC TOPS Transaction Date (per TOPS Trans Query)	PMS Schedule Number	Amount of Disbursement			
1	CDC Overhead	9/30/1998	Not Applicable	(Note 2)	$	-	
	12/31/1998	2/25/1999	PMS1999056	$ 2,910.11			
	3/31/1999	7/14/1999	PMS1999195	$ 10,776.96			
	6/30/1999	9/16/1999	PMS1999259	$ 11,815.21			
	9/30/1999	12/7/2000	PMS2000027	$ 10,077.47			
	12/31/1999	2/29/2000	PMS2000060	$ 59,658.25	$	95,238.00	
			Grand Total		$	95,238.00	

	Oklahoma State DOH's PMS/Quarterly Report of Cash Expenditures (per PMS Inquiry)	PMS reports to CDC TOPS Transaction Date (per TOPS Trans Query)	PMS Schedule Number	Amount of Disbursement			
2a	CDC Overhead	9/30/1999	Not Applicable	$ 14,286.00	$	14,286.00	*(Note 3)*
	12/31/1999	2/29/2000	PMS2000060	$ 3,887.58			
	5/11/2000	5/24/2000	PMS2000146	$ 43,063.10			
	6/30/2000	9/30/2000	900009	$ 51,210.50			
	6/30/2000	1/30/2001	PMS2001031	$ 51,210.50			
	7/1/2000	1/30/2001	PMS2001031	$ (51,210.50)			
	9/30/2000	3/7/2001	PMS2001067	$ 3,500.64			
	12/31/2000	4/17/2001	PMS2001121	$ 81,254.18			
	3/31/2001	6/14/2001	PMS2001239	$ 46,634.97			
	6/30/2001	8/14/2001	PMS2001239	$ 45,042.33			
	9/30/2001	11/8/2001	PMS2001320	$ 11,120.70	$	285,714.00	*(Note 3)*
	For Information Only		Subtotal		$	300,000.00	Tar Creek
	9/30/1999	TAV0009906960		$ 1,667.00			
	9/20/1999	98FED16233		$ 33,333.00	$	35,000.00	AHEC
			Grand Total		$	*335,000.00*	

	PMS/Quarterly Report (per PMS Inquiry)	TOPS Transaction Date (per TOPS Trans Query)	PMS Schedule Number	Disbursement			
2b	CDC Overhead	9/26/2000	Not Applicable	$ 14,286.00	$	*14,286.00*	*(Note 3)*
	9/30/2001	11/8/2001	PMS2001320	$ 22,930.33			
	12/31/2001	2/14/2002	PMS2002058	$ 96,122.63			
	3/31/2002	4/23/2002	PMS2002122	$ 50,633.42	$	169,686.38	
			Grand Total		$	183,972.38	Tar Creek

	PMS/Quarterly Report (per PMS Inquiry)	TOPS Transaction Date (per TOPS Trans Query)	PMS Schedule Number	Disbursement			
3	CDC Overhead	9/28/2001	Not Applicable	$ 14,286.00	$	14,286.00	Tar Creek
			Grand Total		$	14,286.00	

(Note 3): Corresponds with amounts billed to EPA which were provided to ATSDR by EPA Region 6.

SUMMARY OF IAG COSTS PROVIDED TO DATE:

Please refer to:	Report II of May 5, 2003 Package	$	95,238.00
	Report III of May 5, 2003 Package	$	285,714.00
	Report III of May 5, 2003 Package	$	169,686.38
Cooperative Agreement Expenditures (Limited to 272 Quarterly Reports to PMS)		**$**	**550,638.38**
(Refer to Documentation below)			
Please refer to:	Report II of May 5, 2003 Package		(Note 2)
	Report III of May 5, 2003 Package	$	14,286.00
	Report III of May 5, 2003 Package	$	14,286.00
	Report IV of May 5, 2003 Package	$	14,286.00
CDC Indirect Costs		**$**	**42,858.00**

(Note 2): Must obtain additional information from CDC to confirm payment of Indirect Costs associated with this IAG

DOCUMENTATION:
INFORMATION PRINTED FROM THE DIVISION OF PAYMENT MANAGEMENT INTERNET SITE
WWW.DPM.PSC.GOV

[redacted]

Last Updated: Thursday, June 26, 2003

Funding & Requests

Place a SmartLink Request
What we need from you
What you need from us
Funding Request Tutorial
Request Formula
Funding FAQ
Cashline Overview
Federal Agencies
Returning Funds
Recipients Guide

[redacted]

OVERVIEW

DPM DOES NOT AWARD GRANTS. DPM does provide a mechanism for **awarding agencies** to deliver funding to grantees.

There are currently two methods recipients can use to *request* funds.

Request Methods

- **SMARTLINK** - Request funds via a Personal Computer with an Internet or Dial-Up Networking Connection.
- **CASHLINE** - Request funds via a Touch Tone Telephone. Menu driven.

PLEASE NOTE: Recipients may be required to use SmartLink based on the type of account they have.

Request methods are assigned on an account by account basis. Please contact your **account representative** to determine for which method your account qualifies. SmartLink is the preferred method.

Both Request Methods deliver funds to the recipient via Electronic Funds Transfer (EFT). Federal agencies are required to use EFT to the "maximum extent practicable" in making grant payments.

NEXT:

[We Need Information From You »»]
[You Will Need Information From Us »»]
[Funds Request Tutorial »»]
[The Request Formula »»]

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Last Updated: Thursday, June 26, 2003

About DPM

[redacted]

Grant Life Cycle
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PMS Overview
Where is DPM in HHS
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[redacted]

Introduction To DPM

DPM's mission is to provide world class financial and administrative support services to HHS and **other Federal agencies** in the arena of **grant payments** and **cash management**. DPM has 30 years experience providing convenient, cost effective, and efficient grant payment, cash management and grant accounting services.

DPM currently pays out over $195 billion annually in Federal grant-in-aid funds.

During fiscal year 2000, DPM's customers included a wide variety of organizations, over 24,000 in total: **Read about them here.**

DPM operates the **Payment Management System (PMS)**. PMS is a full service centralized grants payment and cash management system. The system has been selected as one of the two grants payment systems for the entire Federal Government. The system is fully automated receiving payment requests, editing them for accuracy and content, transmitting the authorization to either the Federal Reserve Bank or US Treasury for payment, and recording the payment transactions and corresponding disbursement transactions to the appropriate account(s).

DPM's Objectives Include:

- To Provide a Central Point for Grant Payments, Interest Collection and Debt Management
- To Provide for efficient Cash Management
- To Provide Servicing Capability for all Government Agencies
- To Provide Recipients On-Line Capability to Request Funds
- To Provide Agencies On-Line Access to Grant Information
- To Enable operational efficiencies through economies of scale

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[redacted]

Freedom of Information Act | Disclaimers | The White House | FirstGov
U.S. Department of Health & Human Services
200 Independence Avenue, S.W. • Washington, D.C. 20201

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Last Updated: Thursday, June 26, 2003

About DPM

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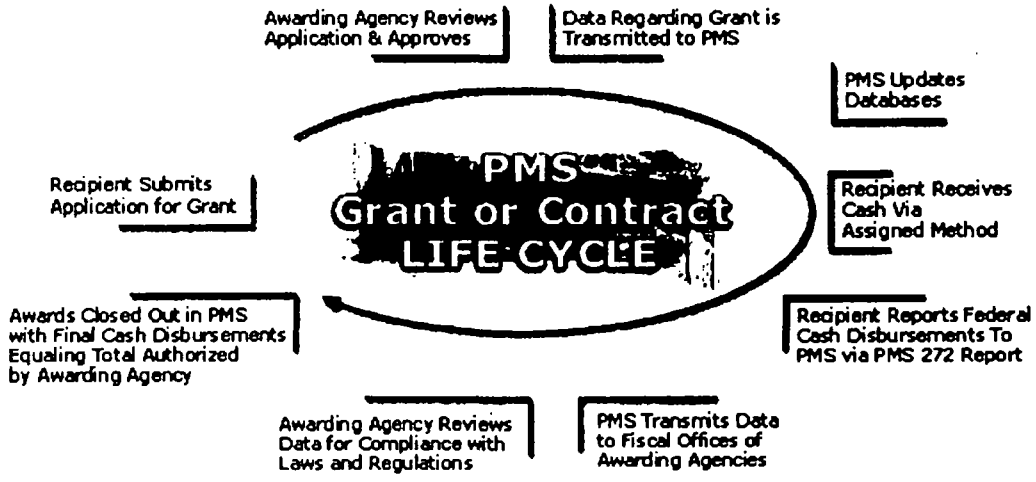
PMS Grant or Contract Life Cycle



Overview:

1. Recipient Submits Application for Grant
2. Awarding Agency Reviews Application & Approves
3. Data Regarding Grant is Transmitted to PMS
4. PMS Updates Databases
5. Recipient **Receives Cash Via Assigned Method**
6. Recipient Reports **Federal Cash Disbursements To PMS Via PMS 272 Report**
7. PMS Transmits Data to Fiscal Offices of Awarding Agencies
8. Awarding Agency Reviews Data for Compliance w/ Laws & Regulations
9. Awards Closed Out in PMS with Final Cash Disbursements Equaling Total Authorized by Awarding Agency

[redacted]

200 Independence Avenue, S.W. • Washington, D.C. 20201

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The DPM Internal Organization:

The Division of Payment Management is comprised of five branches and the *Office of the Director.*

The branches designated as **"Payment Branches"** are the accounting branches which deal with our recipient population and handle their accounts on an account by account level. *These Account Representatives are who recipients deal with most often.* Recipient organizations should be in contact with these accountants to assist in receiving their funding and all reporting issues.

[CLICK HERE to contact DPM Staff]

Director, DPM

Philip Giza

Government & Tribal Payment Branch
(Payment branch - Account Representatives)

- Deals primarily with government entities, such as state and local governments, and Indian Tribes. Approves payments and deals with **all reporting issues.**
- Branch Chief: **Kassandra Miles**

University & Non-Profit Payment Branch
(Payment branch - Account Representatives)

- Deals with colleges, universities, and all other non-profit and for profit recipient organizations. Approves payments and deals with **all reporting issues.**
- Branch Chief: **Stuart Feldsott**

Accounting and Reports Branch

- Responsible for the flow of data; processing of payments and collections; and the preparation of financial reports.
- Branch Chief: **Brian Harris**

Accounting Systems Branch

- Responsible for system integrity, development, & testing.
- Branch Chief: **Stephen Campbell**

Information Systems Branch

- Responsible for system analysis, design, and programming tasks; operating the computerized system; communicating with other computer centers; and providing physical security and backup for the system.
- Branch Chief: **Bob Bessio**

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About DPM

Federal Agencies DPM Provides Services For:

DPM has 30 years experience providing convenient, cost effective, and efficient grant payment, cash management and grant accounting services.

During fiscal year 1999, DPM's customers include a wide variety of organizations, over 22,000 in total:

- 3000+ Colleges & Other Educational Entities
- 8000 Hospitals, Other Health Organizations & Non-Profits
- 4000+ State Government Agencies
- 7000+ Cross-Serviced Non-HHS Accounts
- Many Others ... our customer base is always growing

The CFO Council recently selected the Division of Payment Management / Payment Management System (PMS) as one of only 2 Payment Systems for the FEDERAL GOVERNMENT. **As a result, more Federal agencies have chosen PMS as their payment system.**

Listed below are some of the agencies currently serviced by DPM. This list will soon be growing significantly.

Department of Health and Human Services (HHS)

- Office of the Secretary
- Health Resources and Services Administration
- Food and Drug Administration
- National Institutes of Health
- Centers For Disease Control
- Substance Abuse and Mental Health Services Administration
- Agency for Health Care Research Quality
- Indian Health Service
- Health Care Financing Administration
- Administration for Children and Families
- Administration on Aging

Department of Labor (DOL)

- Mine Safety and Health Administration
- Bureau of Labor Statistics
- Occupational Safety and Health Administration
- Veterans Employment and Training Service
- Employment and Training Administration

Department of the

- U.S. Fish and Wildlife Service

Interior (DOI)	o National Park Service o U.S. Geological Survey
Department of Agriculture (USDA)	o Food and Safety Inspection Service o Cooperative State Research o Education and Extension Service o Agriculture Research Service o Forest Service
Department of Energy (DOE)	o Oak Ridge Operations Office o Chicago Operations Office o Savannah River Operations Office o Morgantown Operations Office o Albuquerque Operations Office o Schenectady Naval Reactors Office o Oakland Operations Office o Richland Operations Office o Nevada Operations Office o Schenectady Naval Reactors Office
NASA	o Ames Research Center o Lewis Research Center o Glenn Research Center o Dryden Flight Research Center o Goddard Space Flight Center o Marshall Space Flight Center o Johnson Space Center o Stennis Space Center
Department of State	o United States Information Agency (USIA)
FEMA	o Federal Emergency Management Administration
Department of the Treasury (Treas)	o U.S. Customs Service
US AID	o United States Agency for International Development
CNS	o Corporation of National Service
	New Customers:
CDFI	o Community Development Financial Institution Fund
HUD	o Department of Housing and Urban Development
SBA	o Small Business Administration

DOS o Department of State

DOT o Department of Transportation

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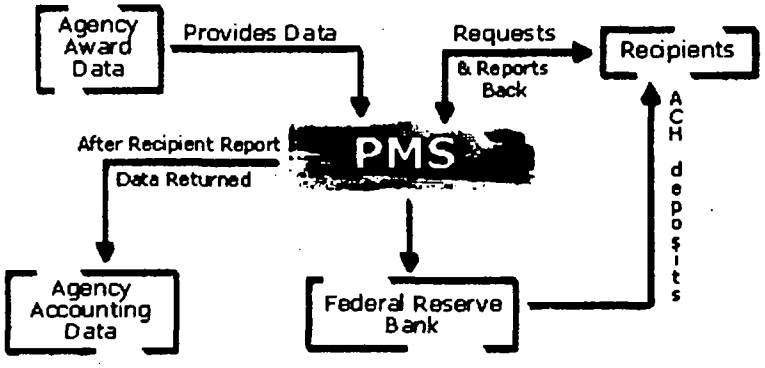
Payment Management System Overview



- Refer to the **GRANT LIFE CYCLE** for further information. **See It Here.**
- **How do Grantees Request Funds?**

The Division of Payment Management operates the Payment Management System (**PMS**). PMS was developed to establish a central point with the capability of paying most Federal Assistance grants, contracts, and block grants. The main purpose of this system is to serve as a fiscal intermediary between awarding agencies and the recipients of grants and contracts, with particular emphasis on: (1) expediting the flow of cash between the Federal Government and recipients; (2) transmitting recipient disbursement data back to the awarding agencies; and (3) managing cash advances to recipients.

The Payment Management System (PMS) operates much like a bank. PMS:

I. **Deposits:** Records Award Authorizations that are initiated by the grant awarding agencies
II. **Withdrawals:** Processes **Recipient's Requests for Funds** using SMARTLINK and CASHLINE
All Payments are Edited for:
   - o Sufficient Funds
   - o Delinquent Reporting
   - o Reasonableness against prior draws, patterns, etc.

III. **Overdraft Protection:** Ensures that a Recipient's Draws Do NOT Exceed Authorizations
IV. **Statements:** Reports Payment Information to the grant awarding agencies on a Daily or Monthly basis

This outline is an overview of each entities Roles / Responsibilities in the grants process:

ENTITY ROLES

Awarding Agency Award Data (pre-payment)	Data regarding a grant or other award to an entity is transmitted to the Payment Management System.
DPM (via PMS)	DPM establishes a recipient account in the PMS System. When a recipient requests funds, DPM initiates payments through of the Federal Reserve Bank in Virginia, which provides next day payments of funds (via ACH Direct Deposit) to recipient's bank accounts.
Recipient	Recipients complete **1199A Direct Deposit Form** in order to register banking data within the Payment Management System. Recipient **requests funding via an assigned payment method thru Payment Management**, which is (generally) paid on a next day basis, and **completes quarterly reports (PMS 272)** which certify the disbursement of the funds.
Federal Reserve Bank	When a recipient requests funds, Payment Management has the Federal Reserve Bank in Virginia initiate an ACH Direct Deposit of funds into the recipient bank account - on a next day basis.
Agency Award Data (post-payment)	Data provided by recipient payments and reporting on the PMS 272 Quarterly report is returned to the Awarding Agencies on a daily or monthly basis.

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About DPM

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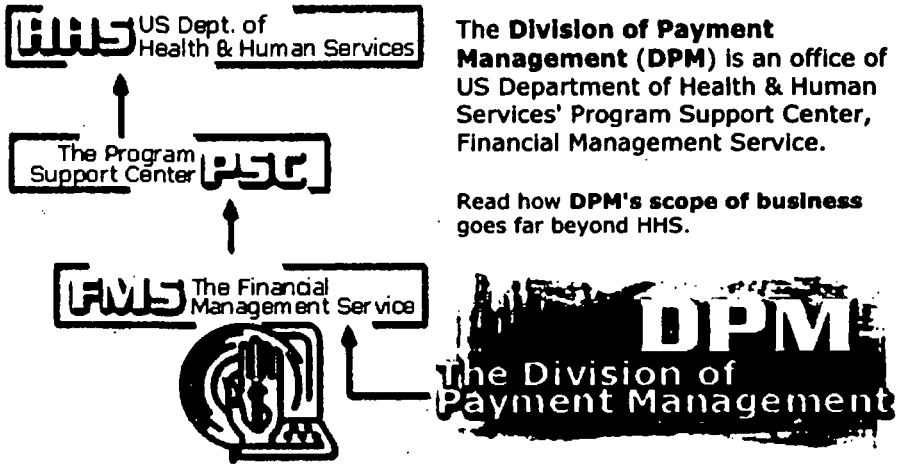
[redacted]

Where is Division of Payment Management in HHS ?



The **Division of Payment Management (DPM)** is an office of US Department of Health & Human Services' Program Support Center, Financial Management Service.

Read how **DPM's scope of business** goes far beyond HHS.

DPM | FMS | PSC | HHS

Within the PSC, the Financial Management Service (**FMS**) operates the CORE central accounting system and performs various financial operations for HHS and other Federal Agencies.

The Program Support Center provides "administrative support services" to HHS components and other Federal Agencies on a fee-for-service basis. Specifically, the PSC's customers include government agencies and organizations with needs for assistance with Personnel, Grants and Contracts, Computer and Information Technology Services, and other Administrative Services. These services are currently being used by over 30 Federal Agencies.

To leave the DPM Website and visit the PSC to learn more, **please click here now.**

[redacted]

[redacted]

Last Updated: Thursday, June 26, 2003

About DPM

DPM Services

The Division of Payment Management provides expert and cutting edge services for both the delivery of funding as well as subsequent Cash Management Services. We offer personalized, one on one Grant Accounting Assistance and implement the latest in technologies to ensure that our users have access to nothing but the best in services available today:

- **Personalized Customer Service**
- **Internet Based Recipient Reporting**
- **Technical Support Help Desk**
- Debt Management
- Account by Account Cash Management to eliminate Idle Cash Balances
- Audit Confirmations and Resolutions
- **Computer Based** or **Touch-Tone Telephone Access** for Funds Requests
- **Extended Hours of Operation For the Entire Country**
- Customer Orientation and Training
- **Centralized Contact Points for Grantees and Agencies**
- Monitored Funds Payments
- 100% Electronic Funds Transfers
- CMIA-90 Legislation Support
- Payment Warehousing (request funds for payment at a later date)
- Enhanced Systems
- Accounting Transactions and Financial Reports
- Electronic Data Financial Reports
- **Interfaced On-line Computer System with Award Authorizations and Disbursements**
- Entity Registration and Updates
- **Grant Recipient Training Classes**

Grant Life Cycle
Internal Organization
Other Agencies
PMS Overview
Where is DPM in HHS
Services

[redacted]

[redacted]

[redacted]

Last Updated: Thursday, June 26, 2003

272 Quarterly Reports

QUARTER AVAILABILITY: **PAPER:** 03-31-03 **ELECTRONIC:** 03-31-03

MAILED WEEK OF: 04-07-03 DUE DATE: 05-15-03 WEB DATA WAS UP ON: 04-08-03

[redacted]

Electronic 272

General Instructions

The PSC 272 Overview

[redacted]

DPM Reporting Overview

PMS recipient reporting requirements are consistent with the OMB policies and the standards for government-wide reporting. DPM uses an automated PSC-272 as approved by OMB for both paper and **ELECTRONIC REPORTING**. These computer-generated reports are furnished to all recipients with active PMS accounts. *A PSC 272 and its appropriate schedules (PSC 272-A through G) are produced for each recipient (payee) account, if applicable.* Since payees may have more than one account in PMS, those payees receive more than one PSC 272.

Samples of the 272 and its subsidiary schedules are listed **HERE**. Each PSC 272 is customized to the needs of a payee's account based on: a) characteristics of the payee; b) characteristics of that account; and c) problems the payee has reported to PMS regarding the data on the PSC 272.

PLEASE NOTE: The samples of the **PSC 272-A** and **PSC 272-B** appear far more complicated than these reports will normally be for the majority of recipients. The intent was to show virtually all possible combinations of problems, conditions and error messages on a single sample of the PSC 272.

- **General Report Completion Instructions**
- **Line By Line Report Documentation**
- **Check Out Our Web-Based Reporting System**

ABOUT 272 MAILINGS & ELECTRONIC DATA AVAILABILITY:

- 272's are generated the FIRST weekend after the end of the quarter.
- Paper 272's are then mailed during the week.
- The **Electronic 272** Data is generally available on the following Monday or Tuesday.
- 272's are due 45 days after the end of the quarter (some agencies may require an earlier submission).

[redacted]

[redacted]

Last Updated: Thursday, June 26, 2003

272 Quarterly Reports

[redacted]

Electronic 272

General Instructions

The PSC 272 Overview

[redacted]

Overviews of PSC 272 Federal Cash Transactions Report

QUARTER AVAILABILITY:	PAPER: 03-31-03	ELECTRONIC: 03-31-03
MAILED WEEK OF: 04-07-03	DUE DATE: 05-15-03	WEB DATA WAS UP ON: 04-08-03

Each PSC 272 report is generated on an account by account basis, so a particular form may not apply to your organization. Click the form title for line by line explanations of each form.

The PSC 272 report is due 45 days after the end of each quarter.

The PSC 272 Quarterly Report

I. Overview of Each Report Form Generated
- **PSC 272 Federal Cash Transactions Report, Status of Federal Cash** [2]
- **PSC 272-A Federal Cash Transactions Report** [1]
- **PSC 272-B Statement of Cash Accountability**
- **PSC 272-C Error Correction Document** [3]
- **PSC 272-E Major Program Statement**
- **PSC 272-F Authorizations for Future Periods**
- **PSC 272-G Inactive Documents Report**

[1, 2] - Indicates order of form completion

[3] - the Electronic 272 has no 272-C

PSC 272 (2)

Form Title: Federal Cash Transactions Report, Status of Federal Cash

Contents: An overview of the cash status of the account. Contains data provided by PMS to the recipient and the net disbursement amount as calculated by the recipient.

Completion Notes:

- This is the certification page of the report. BE SURE TO SIGN IN INK AND RETURN the form to DPM by mail or fax.
- (2) - This page is completed after the **272-A**.
- **Line 4 on this page, Net Disbursements**, is brought forward from the **272-A Net Disbursements** calculation.

PSC 272-A (1)

Form Title: Federal Cash Transactions Report

Contents: Shows the award authorization and prior cumulative disbursements reported against individual awards. The recipient reports net disbursements cumulative through current reporting period.

Completion Notes:

- [1] - Complete this page prior to completing the **272.**
- The **Net Disbursements calculated here** are moved forward to the **272, Line 4.**
- THIS IS A CUMULATIVE REPORT. You must enter your cumulative **Disbursement Amounts in Column E.**
- "PLEASE ENTER DOCUMENTS MISSING FROM ABOVE" - These may be either documents which have not been reported against recently and are listed on the **272-G, Inactive Documents Report**, or other missing awards.

PSC 272-B

Form Title: Statement of Cash Accountability

Contents: Shows the detail of total cash accountability reflected in PMS and a reconciliation report whereby the recipient can indicate payment problems to PMS.

PSC 272-C (Paper Reports Only) [3]

Form Title: Error Correction Document

Contents: Provides an optional mechanism for the recipient to report problems with PMS data systematically and know that follow-up action will be taken.

[3]**Note:** The Electronic 272 has no PSC 272-C Report.

PSC 272-E

Form Title: Major Program Statement

Contents: Shows advances and cash accountability by grant award number and subaccount number.

PSC 272-F

Form Title: Authorizations for Future Periods

Contents: Lists authorizations that have been posted to the PMS database, but for which the starting date has not yet arrived.

PSC 272-G

Form Title: Inactive Documents Report

Contents: Lists all awards posted in the PMS data base that have become inactive during the current period or during a prior period.

Last Updated: Thursday, June 26, 2

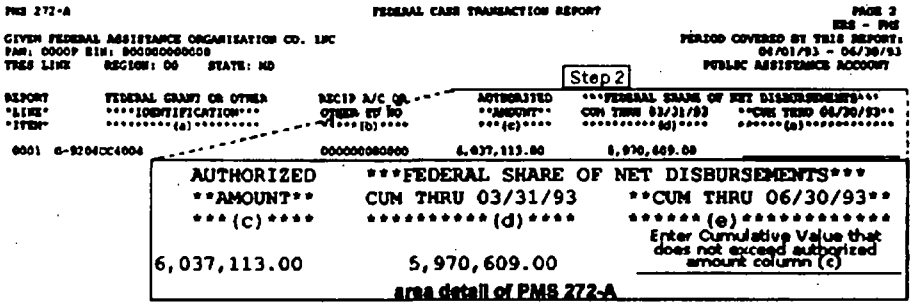
272 Quarterly Reports

Electronic 272
General Instructions
The PSC 272 Overview

General Instructions and things to remember for Completing the 272 Report:

1. Begin filling out the reports on **page two (the 272-A)**.

2. Enter all **cumulative** disbursement data through the quarter covered by the repo in **Column E (on the right hand side of the 272-A)**. These values will appear your next quarter report in prior Quarter Cumulative Disbursements, **Column D**. Please see the diagram below.

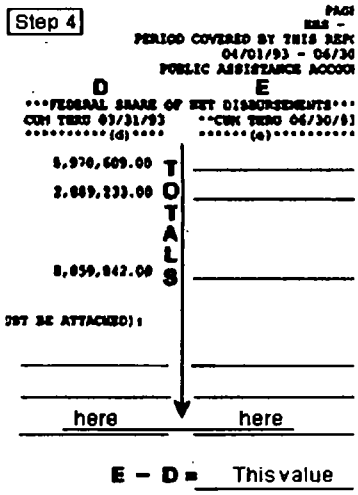


Please note: the value in **Column E** is to be ***CUMULATIVE from the start of the award.***

3. If you have no more disbursements than last quarter to report please enter the same value as is listed in Column D. Please DO NOT enter "$ 0.00" if you reporte disbursements last quarter.

4. If there is a needed adjustment, please enter the correct current (as of that quarter) value of the cumulative disbursements in Column E. **The figures will wash later as it is a cumulative report.**

5. Calculate the **Quarter's (Net) Disbursements** at the bottom of the 272-A by subtracting the total in **Column D** from the total in **Column E**. Please see the diagram to the right.



6. Enter this value on **272 page one, line four (4)**. Proceed with the calculations on down through line 6. Enter values on lines 7, 8, and 9 as applicable.

7. Only original copies and original signatures will be accepted. NO FAXES.

8. Return all pages of the report, including the PSC-272-C and PSC-272-G. **Electronic Users:** please note Electronic 272 Users need only return the PSC 272 certification page.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

STATE COOPERATIVE AGREEMENT DOCUMENTATION

Oklahoma State Department of Health
Financial Management Service

For the period September 29, 1998, through March 31, 2002

for

TAR CREEK (OTTAWA COUNTY) (OU2)
Ottawa County, Oklahoma
CERCLIS NO. OKD980629844

DOCUMENTATION:
COST RECOVERY DOCUMENTATION PROVIDED BY THE OKLAHOMA STATE DEPARTMENT OF HEALTH, FINANCIAL MANAGEMENT SERVICE.

PERSONAL IDENTIFIER(S) REDACTED

ACTUAL COSTS
TAR CREEK COST RECOVERY

	9/29/1998 to 9/28/1999	9/29/1999 to 9/28/2000	9/29/2000 to 9/28/2001	9/29/2001 to 3/31/2002	TOTALS
Personnel	41,141.90	108,194.98	138,379.86	72,702.95	360,419.69
Fees	373.90	9,577.27	4,239.47	982.13	15,172.77
Travel	2,015.17	5,898.19	6,497.80	3,854.14	18,265.30
Equipment	6,250.90	16,170.32	-	0.24	22,421.46
Other	5,059.07	30,672.34	56,180.33	27,180.07	119,091.81
IDC	4,658.25	11,002.21	10,611.36	8,379.29	34,651.11
Total	$ 59,499.19	$ 181,515.31	$ 215,908.82	$ 113,098.82	$ 570,022.14

This schedule is being sent to show the actual supported costs at the Oklahoma State Department of Health for the entire period of time in the original request for Cost Recovery information.

9. New recipients who have not had grant activity must still return the report.
10. DO NOT CHANGE PRE-PRINTED NUMBERS. THIS WILL NOT CORRECT AN ERROR.
11. If you need **help please call for assistance**.

[redacted]

Oklahoma State Department of Health
Leslie M. Beitsch, MD
Commissioner of Health

June 11, 2003

Betty Jones
Cost Recovery Team Leader
1825 Century Boulevard
Mail Stop E-28 (OPOM)
Atlanta, Georgia 30345

RE: Tar Creek Documentation Requested for Cost Recovery (9/29/1998 to 9/28/1999)

Dear Ms. Jones,

In response to your request for Cost Recovery documentation I am sending you the enclosed information. This information covers the period 9/29/1998 to 9/28/1999 for the Program to Build Capacity to Conduct Site-Specific Environmental Health Education Monitoring Activities.

I have this documentation grouped with the same categories identified in the letter from Ken Cadaret to Richard Haj dated June 6, 2002. I have included all costs for this period that we can support with documentation.

If you have any additional question regarding the documentation provided please feel free to contact me at (405) 271-4042.

Respectfully,

Michael D. Truitt
Grants Supervisor
Financial Management Service

Board of Health
Ron L. Graves, DDS, President
John B. Carmichael, DDS
Jay A. Gregory, MD
Haskell L. Evans, Jr, RPh, Vice President
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1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us

An Equal Opportunity Employer

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

DATE 6/26/2003

Oklahoma State Department of Health
State Cooperative Agreement Expenditures (SCA)
Superfund site (60BE), Tar Creek (Ottawa County) (OU2)
Ottawa County, Oklahoma

For the period 9/29/98 to 9/28/99

Personnel	**$**	**41,141.90**
Fees	**$**	**373.90**
Travel	**$**	**2,015.17**
Equipment	**$**	**6,250.90**
Other	**$**	**5,059.07**
Indirect	**$**	**4,658.25**
TOTAL OKLAHOMA SCA COSTS	**$**	**59,499.19**

PERSONAL IDENTIFIER(S) REDACTED

REPORT-ID=[illegible] !

ALPHA SORT

OKLAHOMA DEPARTMENT OF HEALTH
LABOR DISTRIBUTION REPORT(PROGRAM CODE 391 ONLY)
PERIOD 10/01/1998 THRU 09/30/1999

DATE RUN 05/29/2003
PAGE 1

NAME (LAST)	F	PROG	ACT	TASK	OUT	SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
BLANKENSHIP	M	391	010				0.33	0.02	0.35	0.2	3.42	1.20	4.62
		391	021				6.69	1.05	7.74	99.8	81.92	30.71	112.63
SUBTOTAL		391					7.02	1.07	8.09	100.0	85.34	31.91	117.25
TOTAL							7.02	1.07	8.09	100.0	85.34	31.91	117.25
BYRD	L	391	021				7.00	0.21	7.21	100.0	153.57	42.36	195.93
TOTAL							7.00	0.21	7.21	100.0	153.57	42.36	195.93
FOUQUET	S	391	020				0.33	0.05	0.38	0.2	5.02	1.55	6.57
		391	021				22.02	3.11	25.13	99.8	379.67	114.33	494.00
SUBTOTAL		391					22.35	3.16	25.51	100.0	384.69	115.88	500.57
TOTAL							22.35	3.16	25.51	100.0	384.69	115.88	500.57
FROST	T	391	010				10.66	0.78	11.44	6.5	288.78	63.98	352.76
		391	020				7.67	0.68	8.35	4.7	205.73	45.03	250.76
		391	021				42.33	3.39	45.73	88.8	1082.12	260.50	1342.62
SUBTOTAL		391					60.67	4.85	65.52	100.0	1576.63	369.51	1946.14
TOTAL							60.67	4.85	65.52	100.0	1576.63	369.51	1946.14
HICKS	T	391	021				4.33	0.54	4.87	100.0	68.05	22.84	90.89
TOTAL							4.33	0.54	4.87	100.0	68.05	22.84	90.89
HORTON	N	391	010				1.33	0.06	1.39	0.8	20.69	5.76	26.45
		391	020				2.00	0.10	2.10	1.2	31.03	8.65	39.68
		391	021				8.67	0.42	9.09	98.0	131.91	36.74	168.65
SUBTOTAL		391					12.00	0.58	12.58	100.0	183.63	51.15	234.78
TOTAL							12.00	0.58	12.58	100.0	183.63	51.15	234.78
MCBRIDE	J	391	010				0.33	0.02	0.35	100.0	1.58	0.63	2.21
TOTAL							0.33	0.02	0.35	100.0	1.58	0.63	2.21
NICHOLS	J	391	001				112.67	16.37	129.04	73.3	3094.73	784.32	3879.05
		391	010				25.68	2.44	28.12	26.7	710.86	179.14	890.00
SUBTOTAL		391					138.35	18.81	157.16	100.0	3805.59	963.46	4769.05
TOTAL							138.35	18.81	157.16	100.0	3805.59	963.46	4769.05
RONCK	S	391	001				8.00	0.38	8.38	100.0	273.69	66.75	340.44
TOTAL							8.00	0.38	8.38	100.0	273.69	66.75	340.44
WALDRON	S	391	010				37.01	1.93	38.94	22.1	499.82	155.81	655.63
		391	020				1407.00	148.69	1555.69	883.9	17361.09	5871.83	23232.92
		391	021				205.66	18.76	224.42	0.0	2614.51	856.00	3470.51
SUBTOTAL		391					1649.67	169.38	1819.05	906.0	20475.42	6883.64	27359.06
TOTAL							1649.67	169.38	1819.05	906.0	20475.42	6883.64	27359.06

NAME (LAST)	F	PROG	ACT	TASK	OUT	SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
WILLIAMS	K	391	020				8.00	0.73	8.73	6.2	162.16	51.55	213.71
		391	021				5.00	0.45	5.45	93.8	85.34	26.57	111.91
SUBTOTAL		391					13.00	1.18	14.18	100.0	247.50	78.12	325.62
TOTAL							13.00	1.18	14.18	100.0	247.50	78.12	325.62
GRAND TOTAL							1,922.72	200.18	2,122.90	100.0	27,255.69	8,626.25	35,881.94

PERSONNEL

9/29/1998 to 9/28/1999

TE005	35,881.94
PGM 301	4,881.13
Sub-Total	40,763.07
Adjustments to TE005	378.83
Total Personnel	$ 41,141.90

PERSONAL IDENTIFIER(S) REDACTED

OKLAHOMA DEPARTMENT OF HEALTH
LABOR DISTRIBUTION REPORT(PROGRAM CODE 391 ONLY)
PERIOD 10/01/1998 THRU 09/30/1999

NAME (LAST)	F	PROG	ACT	TASK	OUT SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
BLANKENSHIP	M	391	010			0.33	0.02	0.35	0.2	3.42	1.20	4.62
		391	021			6.69	1.05	7.74	99.8	81.92	30.71	112.63
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TOTAL						7.02	1.07	8.09	100.0	85.34	31.91	117.25
BYRD	L	391	021			7.00	0.21	7.21	100.0	153.57	42.36	195.93
TOTAL						7.00	0.21	7.21	100.0	153.57	42.36	195.93
FOUQUET	S	391	020			0.35	0.03	0.38	0.2	5.02	1.55	6.57
		391	021			22.02	3.11	25.13	99.8	379.67	114.33	494.00
SUBTOTAL		391				22.35	3.16	25.51	100.0	384.69	115.88	500.57
TOTAL						22.35	3.16	25.51	100.0	384.69	115.88	500.57
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TOTAL						4.33	0.54	4.87	100.0	68.05	22.84	90.89
HORTON	N	391	010			1.33	0.06	1.39	0.8	20.69	5.76	26.45
		391	020			2.00	0.10	2.10	1.2	31.03	8.65	39.68
		391	021			8.67	0.42	9.09	98.0	131.91	36.74	168.65
SUBTOTAL		391				12.00	0.58	12.58	100.0	183.63	51.15	234.78
TOTAL						12.00	0.58	12.58	100.0	183.63	51.15	234.78
MCBRIDE	J	391	010			0.33	0.02	0.35	100.0	1.58	0.63	2.21
TOTAL						0.33	0.02	0.35	100.0	1.58	0.63	2.21
NICHOLS	J	391	001			112.67	16.37	129.04	73.3	3094.73	784.32	3879.05
		391	010			25.68	2.44	28.12	26.7	710.86	179.14	890.00
SUBTOTAL		391				138.35	18.81	157.16	100.0	3805.59	963.46	4769.05
TOTAL						138.35	18.81	157.16	100.0	3805.59	963.46	4769.05
RONCK	S	391	001			8.00	0.38	8.38	100.0	273.69	66.75	340.44
TOTAL						8.00	0.38	8.38	100.0	273.69	66.75	340.44
WALDRON	S	391	010			37.01	1.93	38.94	22.1	499.82	155.81	655.63
		391	020			1407.00	148.69	1555.69	883.9	17361.09	5871.83	23232.92
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SUBTOTAL		391				1649.67	169.38	1819.05	906.0	20475.42	6883.64	27359.06
TOTAL						1649.67	169.38	1819.05	906.0	20475.42	6883.64	27359.06

REPORT-ID=TE005

PHA SORT

OKLAHOMA DEPARTMENT OF HEALTH
LABOR DISTRIBUTION REPORT(PROGRAM CODE 391 ONLY)
PERIOD 10/01/1998 THRU 09/30/1999

DATE RUN 05/29/2003

NAME (LAST)	F	PROG	ACT	TASK	OUT SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
WILLIAMS	K	391	020			8.00	0.73	8.73	6.2	162.16	51.55	213.71
		391	021			5.00	0.45	5.45	93.8	85.34	26.57	111.91
SUBTOTAL		391				13.00	1.18	14.18	100.0	247.50	78.12	325.62
TOTAL						13.00	1.18	14.18	100.0	247.50	78.12	325.62
GRAND TOTAL						1,922.72	200.18	2,122.90	100.0	27,255.69	8,626.25	35,881.94

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Melanie Blankenship

Month 01 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	301	021		02	00	058						
2	25	250	020		06	00	058						
3	26	250	022		00	40	058			58930069	58910025	58920037	58990001
4	26	301	004		00	40	058			58930004	58930002		
5	26	250	010		00	20	058						
6	26	250	020		06	20	058						
7	27	301	021		03	00	058						
8	27	250	020		05	00	058						
9	28	391	021		03	00	058						
10	28	250	020		05	00	058						
11	29	301	021		04	00	058						
12	29	250	020		03	20	058						
13	29	250	010		00	40	058						
14													
15													
16													
17													
18													

ENTERED
MAR 05 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Melanie Blankenship

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Melanie Blankenship

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	01	241	021		00	20	058						
2	01	250	020		06	30	058						
3	01	257	021		00	20	058						
4	01	266	021		00	20	058						
5	01	391	021		00	40	058						
6	02	250	020		08	00	058						
7	03	250	020		07	40	058						
8	03	250	022		00	20	058			[illegible]	[illegible]	[illegible]	[illegible]
9	04	250	020		07	00	058			[illegible]			
10	04	250	022		01	00	058			[illegible]	[illegible]	[illegible]	[illegible]
11	05	250	020		08	00	058			[illegible]	[illegible]	[illegible]	[illegible]
12										[illegible]	[illegible]		
13													
14													
15													
16													
17													
18													

ENTERED JUN [illegible] 1999 TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Melanie Blankenship

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Melanie Blankenship

Month 04 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	05	250	020		08	00	058						
2	06	250	020		06	00	058						
3	06	391	021		01	40	058			58980081	58990003	58950050	58990055
4	06	250	022		00	20	058						
5	07	250	020		08	00	058						
6	08	250	020		07	00	058			58980081	58990003	58950050	58990055
7	08	250	022		01	00	058			18990049	18990063	18990033	18990018
8	09	250	020		08	00	058			18930055	18900050	18990045	
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

RECEIVED JUL 06 T&E EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Melanie Blankenship

Supervisor's Signature Jane Ann Nichols LMLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Melanie Blankenship

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	250	020		07	00	058						
2	20	266	020		01	00	058						
3	21	250	020		06	20	058						
4	21	391	021		01	20	058						
5	21	391	010		00	20	058						
6	22	250	010		01	20	058						
7	22	250	020		06	40	058						
8	23	250	020		07	40	058						
9	23	250	124		00	20	058						
10	24	250	020		08	CC	058						
11													
12													
13													
14													
15													
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18													

NOV 10

TIME SHEET

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Melanie Blankenship

Supervisor's Signature Jane Ann Nichols
TLB

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 575 #2

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	301	003		06	00							
2	23	391	021		02	40							
3	23	289	021		01	00							
4	23	378	021		00	20							
5	23	385	021		02	00							
6	23	330	021		01	00							
7	23	287	021		01	00							
8	24	330	021		01	40							
9	24	374	021		02	00							
10	24	289	021		02	00							
11	24	233	021		01	20							
12	24	378	021		01	00							
13	25	330	021		02	00	WORK WEEK ADJUSTMENT						
14	25	287	021		02	00							
15	25	385	021		01	00							
16	25	233	021		03	00							
17	25	289	021		01	00							
18	26	391	021		01	00							

ENTERED
MAY 10 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature [signature] MS

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2 of 5

Employee Sonja Joyce Fawcett

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	15	301	009		08	00							
2	16	291	021		00	40							
3	16	388	021		00	40							
4	16	233	021		05	20							
5	16	317	021		01	00							
6	16	289	021		02	00							
7	16	287	021		00	20							
8	17	289	021		05	00							
9	17	374	021		01	00							
10	17	233	021		01	00							
11	17	287	021		00	40							
12	17	330	021		00	20							
13	18	289	021		08	00							
14	19	289	021		08	00							
15													
16													
17													
18													

ENTERED
MAY 19 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fawcett

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	233	021		04	00							
2	29	383	021		01	00							
3	29	374	021		02	00							
4	29	287	021		01	00							
5	30	233	021		03	00							
6	30	378	021		01	00							
7	30	289	021		01	00							
8	30	385	021		01	00							
9	30	391	021		01	00							
10	30	374	021		01	00							
11	31	383	021		05	00							
12	31	233	021		01	40							
13	31	289	021		01	00							
14	31	374	021		00	20							
15													
16													
17													
18													

ENTERED
JUN 24 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee SONJA JOYCE FOUQUET

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	374	021		03	00							
2	22	391	021		01	20							
3	22	383	021		01	00							
4	22	233	021		02	40							
5	23	330	021		01	00							
6	23	233	021		02	00							
7	23	385	021		01	00							
8	23	374	021		02	00							
9	23	289	021		02	00							
10	24	233	021		04	00							
11	24	391	020		00	20							
12	24	374	021		02	00							
13	24	383	021		01	00							
14	24	330	021		01	00							
15	25	385	021		01	00							
16	25	383	021		01	00							
17	25	374	021		01	00							
18	25	233	021		01	20							

ENTERED
MAY 19 1999
TIME & EFFOR

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Morley

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee SONJA JOYCE FOUQUET

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	301	003		03	00	ADJUSTED WORKWEEK						
2	09	301	021		01	20							
3	09	287	021		07	00							
4	10	287	021		02	00							
5	10	289	021		05	00							
6	10	288	021		01	40							
7	10	374	021		01	00							
8	11	374	021		04	00							
9	11	289	021		02	00							
10	11	287	021		01	00							
11	11	391	021		01	00							
12	11	233	021		02	00							
13	12	374	021		01	40							
14	12	289	021		03	00							
15	12	233	021		03	00							
16	12	330	021		01	20							
17													
18													

RECEIVED JUN 24 1999 FINAL REPORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	233	021		03	00							
2	01	374	021		01	00							
3	01	289	021		01	00							
4	01	301	0002		01	00							
5	02	391	021		01	00							
6	02	233	021		03	00							
7	02	330	021		01	00							
8	02	374	021		01	00							
9	02	378	021		01	00							
10	02	385	021		01	00							
11	03	349	021		01	00							
12	03	330	021		01	00							
13	03	233	021		03	00							
14	03	289	021		04	00							
15	04	289	021		07	00							
16	04	233	021		01	00							
17	05	289	021		06	00							
18	05	383	021		03	00	OKMW						

ENTERED
JUN 24 [illegible]
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee SONJA JOYCE FOUQUET

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	383	021		01	00							
2	05	385	021		01	00							
3	05	233	021		02	00							
4	05	374	021		02	00							
5	05	289	021		01	00							
6	06	301	021		08	00							
7	07	374	021		01	00							
8	07	287	021		02	00							
9	07	233	021		02	00							
10	07	288	021		03	00							
11	08	385	021		01	00							
12	08	391	021		02	00							
13	08	233	021		01	00							
14	08	287	021		04	00							
15	08	289	021		01	00							
16	09	301	021		08	00	Adjusted Work Week						
17													
18													

ENTERED
JUN 29 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Yvonne Myers

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee SONJA JOYCE FOUQUET

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	37402	1		03	40							
2	01	391	021		00	40							
3	01	287	021		02	40							
4	01	289	021		01	00							
5	02	3001	003		08	00							
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
JUN 2 5 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	239	021		03	00							
2	27	385	021		00	40							
3	27	388	021		00	40							
4	27	289	021		01	40							
5	28	233	021		03	00							
6	28	287	021		02	00							
7	28	289	021		02	00							
8	28	391	021		01	00							
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
SEP 27 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Maloy

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	378	021		01	00							
2	24	391	021		01	00							
3	24	377	021		01	00							
4	24	383	021		01	00							
5	24	233	021		01	00							
6	24	385	021		01	00							
7	24	374	021		03	00							
8	24	289	021		01	00							
9	25	374	021		03	00							
10	25	349	021		01	00							
11	25	233	021		03	00							
12	25	289	021		01	00							
13	25	383	021		01	00							
14	26	383	021		01	00		AWV		ENTERED SEP 2x 1999 TIME & EFFORT			
15	26	233	021		03	00							
16	26	391	021		01	00							
17	26	289	021		02	00							
18	26	385	021		01	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	374	021		03	00							
2	03	233	021		02	20							
3	03	383	021		00	20							
4	03	388	021		00	20							
5	04	383	021		01	00							
6	04	233	021		04	00							
7	04	378	021		01	00							
8	04	377	021		01	00							
9	04	289	021		02	00							
10	05	391	021		02	00							
11	05	377	021		04	00							
12	05	374	021		01	00							
13	05	233	021		01	00							
14	06	377	021		04	00							
15	06	378	021		02	00							
16	06	285	021		02	00		Adjusted work week					
17	06	388	021		01	00							
18	07	301	003		08	00							

ENTERED SEP 21 1999 TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	330	021		01	00							
2	14	233	021		02	00							
3	14	378	021		01	00							
4	14	383	021		02	00							
5	14	384	021		01	00							
6	14	369	021		01	00							
7	15	233	021		04	00							
8	15	385	021		02	00							
9	15	369	021		02	00							
10	16	287	021		02	00							
11	16	388	021		02	00							
12	16	391	021		02	00							
13	16	385	021		01	00							
14	16	374	021		01	00							
15	17	374	021		01	00							
16	17	385	021		03	00							
17	17	233	021		03	00							
18	17	377	021		01	00							

ENTERED
SEP 23 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Morley

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	374	021		08	00							
2	20	374	021		03	00							
3	20	391	021		00	40							
4	20	383	021		00	40							
5	20	233	021		03	00							
6	20	285	021		01	20							
7	21	374	021		02	00							
8	21	233	021		03	00							
9	21	391	021		01	00							
10	21	289	021		01	00							
11	21	287	021		01	00							
12	22	374	021		07	20							
13	23	385	021		02	00							
14	23	374	021		03	00	adjusted Work Week						
15	23	233	021		03	00							
16													
17													
18													

ENTERED
OCT 25 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

OPM Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	233	021		01	00							
2	23	374	021		01	00							
3	23	289	021		01	00							
4	23	287	021		01	00							
5	23	385	021		02	00							
6	23	391	021		01	00							
7	23	378	021		01	00							
8	24	233	021		02	00							
9	24	374	021		02	00							
10	24	330	021		03	00							
11	24	289	021		01	20							
12	25	374	021		04	00							
13	25	330	021		00	20							
14	25	385	021		03	40							
15	26	378	021		01	40				ENTERED			
16	26	385	021		03	00				OCT 27 1999			
17	26	287	021		01	00				TIME & EFFORT			
18	26	233	021		02	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page Page 3 of 3

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	233	021		02	00							
2	16	385	021		03	00							
3	16	374	021		01	00							
4	16	289	021		02	40							
5	17	301	0003		08	00							
6	18	301	0003		01	20							
7	18	233	021		03	00							
8	18	385	021		03	00							
9	19	374	021		01	00							
10	19	330	021		03	00							
11	19	289	021		04	00							
12	20	330	021		01	00							
13	20	233	021		04	00							
14	20	369	021		01	00		Adjustment Worksheet					
15	20	391	021		01	00							
16	20	385	021		01	00							
17													
18													

ENTERED

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	231	010		02	00	058						
2	19	231	021		02	00	058						
3	19	231	020		02	00	058						
4	19	318	020		01	00	058						
5	19	374	021		01	00	058						
6	20	231	021		01	00	018						
7	20	318	020		03	00	018						
8	20	266	020		01	00	018						
9	20	231	020		03	00	018						
10	21	231	020		05	00	018						
11	21	231	021		01	40	018						
12	21	246	020		01	20	018						
13	22	264	020		02	00	018						
14	22	231	021		06	00	018			ENTERED			
15	23	231	020		04	00	058						
16	23	231	021		01	40	058						
17	23	231	010		01	20	058						
18	23	391	020		01	00	058						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

[redacted]

Month 05 Year 97

Line #	Activity Date	[redacted]	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	23 1	010		01	20	058						
2	17	23 1	020		03	40	058						
3	17	23 1	021		02	00	058						
4	17	39 1	021		01	00	058						
5	18	39 1	010		03	00	058						
6	18	39 1	021		05	00	058						
7	19	23 1	010		03	20	058						
8	19	23 1	021		04	40	058						
9	20	[redacted]	020		01	00	013						
10	20	23 1	021		05	00	013						
11	20	24 4	021		02	00	018						
12	21	23 1	010		01	20	058						
13	21	23 1	020		03	40	058						
14	21	23 1	021		02	00	058						
15	21	39 1	021		01	00	058						
16													
17													
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ENTERED
SEP 02 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature [redacted]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 97

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	231	010		03	00	058						
2	10	231	021		05	00	058						
3	11	318	010		02	40	058						
4	11	318	021		05	20	058						
5	12	391	010		02	00	058						
6	12	391	021		06	00	058						
7	13	231	010		01	20	058						
8	13	231	020		04	40	058						
9	13	231	021		01	00	058						
10	13	246	020		01	00	055						
11	14	231	010		01	20	058						
12	14	231	020		04	00	058						
13	14	231	021		00	40	053						
14	14	391	021		02	00	058						
15													
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17													
18													

ENTERED
AUG 23 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	231	010		012	0	058						
2	21	231	020		03	00	058						
3	21	231	021		01	00	058						
4	21	266	020		01	00	058						
5	21	391	020		01	40	058						
6	22	231	020		06	00	018						
7	22	231	021		01	00	018						
8	22	266	020		01	00	018						
9	23	231	020		03	00	018						
10	23	231	021		01	00	018						
11	23	318	021		04	00	018						
12	24	231	010		01	20	058						
13	24	231	020		05	40	058						
14	24	231	021		01	00	058						
15	25	391	010		01	20	058						
16	25	391	021		06	40	058						
17													
18													

ENTERED
OCT 1 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	301	003		08	00	018						
2	15	231	020		04	00	018						
3	15	231	021		01	00	018						
4	15	266	020		01	00	018						
5	16	318	020		04	00	018						
6	16	231	020		04	00	018						
7	17	231	010		01	20	058						
8	17	231	020		04	40	058						
9	17	231	021		02	00	058						
10	18	231	010		01	20	058						
11	18	391	020		01	00	058						
12	18	391	021		01	40	058						
13	18	231	020		04	00	058						
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ENTERED
OCT 1 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	231	010		03	00	018						
2	07	231	021		05	00	018						
3	08	218	021		03	00	058						
4	08	218	010		04	00	058						
5	08	246	021		02	00	018						
6	08	231	020		02	00	018						
7	09	231	020		01	20	018						
8	09	256	020		01	20	018						
9	09	257	020		01	20	018						
10	09	231	021		04	00	018						
11	10	231	010		01	20	058						
12	10	231	020		03	40	058						
13	10	231	021		01	00	058						
14	10	391	021		02	00	058						
15	11	231	010		01	20	058						
16	11	231	021		02	40	058						
17	11	301	003		04	00	018						
18													

SEP 23 1999

TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols/CA

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	231	021		05	00	018						
2	01	266	020		03	00	018						
3	02	231	021		04	00	018						
4	02	257	020		02	00	018						
5	02	243	021		02	00	018						
6	03	231	010		01	20	058						
7	03	231	020		05	40	058						
8	03	231	021		01	00	058						
9	04	231	010		02	00	058						
10	04	391	021		03	00	058						
11	04	231	021		03	00	058						
12													
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14													
15													
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17													
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ENTERED

SEP 23 1999

TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	231	010		02	00	058						
2	12	231	020		02	00	058						
3	12	231	021		01	00	058						
4	12	391	020		01	00	058						
5	12	391	021		02	00	058						
6	13	318	021		04	00	018						
7	13	231	020		04	00	018						
8	14	231	020		06	00	018						
9	14	231	021		01	00	018						
10	14	266	020		01	00	018						
11	15	231	020		04	00	058						
12	15	231	021		02	00	058						
13	15	231	010		01	20	058						
14	16	231	020		02	00	058						
15	16	231	021		02	00	058						
16	16	231	010		02	00	058						
17	16	391	021		02	00	058						
18													

ENTERED
OCT 25 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	231	010		0120	058							
2	20	231	020		0600	058							
3	20	231	021		0040	058							
4	21	231	020		0540	018							
5	21	266	020		0120	018							
6	21	231	021		0100	018							
7	22	231	020		0340	018							
8	22	231	021		0020	018							
9	28	318	021		0400	018							
10	23	391	010		0300	058							
11	23	391	021		0500	058							
12	24	240	010		0120	058							
13	24	231	010		0200	058							
14	24	240	021		0220	018							
15	24	231	021		0220	018							
16													
17													
18													

ENTERED
NOV 15 1999
T... & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost ARNP

Supervisor's Signature [illegible]

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	301	009		08	00	018						
2	07	318	021		04	00	018						
3	07	231	020		04	00	018						
4	08	231	020		05	00	018						
5	08	231	021		01	20	018						
6	08	266	020		01	40	018						
7	09	231	020		04	00	058						
8	09	231	021		01	20	058						
9	09	391	020		01	00	058						
10	09	391	021		00	20	058						
11	09	231	010		01	20	058						
12	10	231	010		01	20	058						
13	10	231	021		05	40	058						
14	10	391	021		01	00	058						
15													
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ENTERED
NOV 15 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Judy L Frost

Supervisor's Signature [illegible]

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Trudy L. Frost ARNP

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		0120	058							
2	01	391	021		0340	058							
3	01	231	020		0100	018							
4	01	231	021		0200	018							
5	02	391	020		0200	058							
6	02	231	010		0120	058							
7	02	231	020		0440	058							
8	03	301	002		0800	018							
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ENTERED
NOV 15 1999

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost ARNP

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Tina Hicks

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 95

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	233	021		02	00							
2	30	257	021		05	00							
3	20	391	021		00	20							
4	30	377	021		00	20							
5	30	338	021		00	20							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tina R. Hicks

Supervisor's Signature Peggy A Morby ms

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee TINA Hicks

Month 12 Year 98

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	257	021		08	00							
2	08	233	021		08	00							
3	09	233	021		06	00							
4	09	301	003		02	00							
5	10	369	021		02	00							
6	10	388	021		02	00							
7	10	349	021		02	00							
8	10	391	021		02	00							
9	11	301	003		03	00							
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ENTERED
FEB 12 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tina B. Hicks

Supervisor's Signature Gregory A Mosley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee TINA Hicks

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	301	003		01	00							
2	04	257	021		07	00							
3	05	233	021		08	00							
4	06	388	021		04	00							
5	06	391	021		04	00							
6	07	257	021		08	00							
7	08	233	021		08	00							
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ENTERED
MAR 10 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tina R. Hicks

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Month 09 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	021		04	00	058						
2	01	241	020		04	00	058						
3	02	231	020		06	00	058						
4	02	391	020		01	00	058						
5	02	266	020		01	00	058						
6	03	340	020		03	00	058						
7	03	252	020		03	00	058						
8	03	241	020		02	00	058						
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ENTERED
NOV 15 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols VNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	266	020		05	00	058						
2	13	340	020		01	00	058						
3	13	241	020		01	00	058						
4	13	252	020		01	00	058						
5	14	241	020		07	60	058						
6	14	266	020		01	00	058						
7	15	241	020		08	00	058						
8	16	266	020		05	00	058						
9	16	340	020		01	00	058						
10	16	270	020		02	00	058						
11	17	391	010		01	20	058						
12	17	391	021		04	40	058						
13	17	241	020		02	00	058						
14													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols GNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	241	020		02	00	058						
2	20	340	020		01	00	058						
3	20	266	020		04	00	058						
4	20	270	020		01	00	058						
5	21	266	020		02	00	058						
6	21	391	020		01	00	058						
7	21	241	020		05	00	058						
8	22	241	020		02	00	058						
9	22	340	020		03	00	058						
10	22	252	020		03	00	058						
11	23	266	020		05	00	058						
12	23	340	020		01	00	058						
13	23	241	020		02	00	058						
14	24	231	010		03	00	058						
15	24	231	021		02	00	058						
16	24	241	020		03	00	058						
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols MD

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Jane Ann Nichols

Month 05 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	301	010		02	00	018						
2	24	301	001		03	00	018						
3	24	301	001		03	00	058						
4	25	391	001		08	00	058						
5	26	301	001		08	00	058						
6	27	301	003		02	00	058						
7	28	301	010		01	20	018						
8	27	301	001		04	40	018						
9	28	301	010		03	00	058						
10	28	301	001		05	00	058						
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ENTERED
SEP 03 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
JUN 10 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Jane Ann Nichols

Month 05 Year 99

Social Security Number -PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	301	010		01	20	018						
2	12	301	001		06	40	018						
3	18	391	010		03	00	058						
4	18	391	001		05	00	058						
5	19	301	010		01	20	018						
6	19	301	001		06	40	018						
7	20	301	001		08	00	058						
8	20	391	001		02	00	058						
9	21	301	001		08	00	058						
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ENTERED
SEP 03 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
JUN 10 1999
LOCAL HEALTH SERVICES

Employee's Signature Jane Nichols

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2 of 10

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	010		03	00	058						
2	10	391	001		05	00	058						
3	11	301	003		08	00	058						
4	12	391	010		02	00	058						
5	12	391	001		04	00	058						
6	12	391	001		02	00	058						
7	13	301	001		08	00	058						
8	14	301	010		03	00	018						
9	14	301	001		05	00	018						
10													
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ENTERED
SEP 03 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
JUN 10 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Gayle Carpenter

ODH Form 4

10

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	3911	010		01	20	018						
2	03	3911	001		06	40	018						
3	04	3011	010		04	00	058						
4	04	3011	001		04	00	058						
5	05	3011	001		04	00	008						
6	05	3011	010		04	00	018						
7	06	3911	001		08	00	058						
8	07	3011	010		01	20	018						
9	07	3011	001		06	40	018						
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SEP 30 1999

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
JUN 10 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Wayne Carson

ODH Form 4

12

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	301	010		01	40	018						
2	21	301	001		06	20	018						
3	22	301	001		04	00	058						
4	22	301	004		04	00	058						
5	23	301	003		02	40	058						
6	23	301	001		05	20	058						
7	24	301	010		01	40	018						
8	24	301	001		06	20	018						
9	25	301	002		01	00	058						
10	25	301	010		02	00	058						
11	25	391	001		05	00	058						
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ENTERED
SEP 23 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
JUL 28 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Gayle Carpenter

13

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	301	003		03	20	058						
2	07	391	001		04	20	058						
3	07	391	610		00	20	058						
4	08	301	010		08	00	058						
5	09	301	003		02	20	058						
6	09	301	010		01	20	018						
7	09	301	001		04	20	018						
8	10	301	010		01	20	018						
9	10	301	001		06	40	018						
10	11	301	001		03	00	058						
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SEP 27 1999
T&E

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LOCAL HEALTH SERVICES

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jane Nichols

Supervisor's Signature Wayne Carper

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Month 07 Year 99

[redacted] Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	301	002		08	00	058						
2	20	301	001		06	00	058						
3	20	391	001		02	00	058						
4	21	391	001		02	00	058						
5	21	301	001		06	00	058						
6	22	301	001		06	00	058						
7	22	301	010		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

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SEP 24 1999
LOCAL HEALTH SERVICES

Supervisor's Signature Doyle Carpenter ~~Jane Ann Nichols~~ error lines

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

,ee Jane Ann Nichols

Month 07 Year 99

.ial Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	301	009		08	00	058						
2	06	301	001		08	00	058						
3	07	391	001		08	00	058						
4	08	301	002		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

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JUL 2 8 1999
LOCAL HEALTH SERVICES

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	301	001		08	00	058						
2	03	301	001		08	00	058						
3	04	301	010		01	20	018						
4	04	391	001		06	40	018						
5	05	391	010		03	20	058						
6	05	391	001		04	40	058						
7	06	301	001		06	00	058						
8	06	301	002		02	00	058						
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ENTERED
OCT 27 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
SEP 24 1999
OCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Doyle Carp

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Jane Ann Nichols

Month 08 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	301	001		08	00	058						
2	[illegible]	301	003		08	00	058						
3	11	391	001		08	00	058						
4	12	301	010		01	20	018						
5	12	301	001		06	40	018						
6	13	301	001		03	00	058						
7	13	301	010		01	00	018						
8	13	301	001		03	00	018						
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ENTERED
OCT 27 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
SEP 24 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Doyle Carpenter

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	010		02	00	058						
2	23	391	001		06	00	058						
3	24	301	010		01	40	018						
4	24	301	001		06	20	018						
5	25	301	003		08	00	058						
6	26	301	001		08	00	058						
7	27	301	001		08	00	058						
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ENTERED
OCT 27 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
SEP 24 1999
CAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Gayle Cooper

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee J. Nichols

Month 09 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	301	001		08	00	058						
2	28	391	010		02	00	058						
3	28	391	001		06	00	058						
4	29	391	010		06	00	058						
5	29	391	001		02	00	058						
6	30	301	001		08	00	058						
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ENTERED
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
OCT 18 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Doyle Carpe

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 02

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	301	009		08	00	058						
2	07	301	001		06	00	058						
3	07	391	001		02	00	058						
4	08	301	010		01	20	018						
5	08	301	001		06	40	018						
6	09	301	010		01	20	018						
7	09	301	001		06	40	018						
8	10	391	010		02	40	058						
9	10	391	001		04	20	058						
10	10	301	002		01	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

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SEP 24 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Doyle Cason

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 01

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	001		08	00	058						
2	02	301	001		08	00	058						
3	03	301	001		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
SEP 24 1999
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature Doyle Carson

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	266	021		06	00	058						
2	26	301	021		02	00	058						
3	27	391	020		06	00	058						
4	27	241	020		02	00	058						
5	28	241	020		06	00	058						
6	28	391	020		02	00	058						
7	29	391	020		05	40	058						
8	29	301	021		02	20	058						
9	30	391	020		06	00	058						
10	30	241	021		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (JNC)

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	241	021		05	00	058						
2	12	301	010		03	00	058						
3	13	241	021		05	00	058						
4	13	301	010		03	00	058						
5	14	301	021		08	00	058						
6	15	241	021		04	00	058						
7	15	301	021		04	00	058						
8	16	391	020		05	00	058						
9	16	241	021		02	00	058						
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ENTERED
NOV 06 1998
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
CNE

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 98

Line #	Activity Date	[redacted]	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	[redacted]	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (JAN B)

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	020		0800	058							
2	24	391	020		0600	058							
3	24	301	021		0200	058							
4	25	391	020		0800	058							
5	26	301	009		0800	058							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	39 1	021		08	00	058						
2	17	39 1	021		08	00	058						
3	18	39 1	021		08	00	058						
4	19	39 1	021		08	00	058						
5	20	39 1	021		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [signature] NLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 95

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		06	00	058						
2	09	301	021		02	00	058						
3	10	391	020		06	00	058						
4	10	301	021		02	00	058						
5	11	301	009		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1 of 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		05	00	058						
2	02	241	020		03	00	058						
3	03	391	020		07	00	058						
4	03	241	020		01	00	058						
5	04	301	010		06	00	058						
6	04	238	021		02	00	058						
7	05	391	020		04	00	058						
8	05	301	021		04	00	058						
9	06	391	020		04	00	058						
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ENTERED
DEC 09 1998
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols LNCB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	301	002		08	00	058						
2	29	391	020		08	00	058						
3	30	391	020		08	00	058						
4	31	391	020		08	00	058						
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ENTERED
FEB 03 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols UMB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	301	003		08	00	058						
2	22	391	020		08	00	058						
3	23	391	020		08	00	058						
4	24	301	002		04	00	058						
5	24	391	020		04	00	058						
6	25	301	009		08	00	058						
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ENTERED
FEB 03 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
JNS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	020		08	00	058						
2	15	391	020		07	00	058						
3	15	391	021		01	00	058						
4	16	391	020		04	00	058						
5	16	301	021		04	00	058						
6	17	391	020		08	00	058						
7	18	301	010		02	00	058						
8	18	391	020		06	00	058						
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FEB 03 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (JNB)

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	020		06	00	058						
2	07	301	021		02	00	058						
3	08	391	020		08	00	058						
4	09	391	020		08	00	058						
5	10	301	003		08	00	058						
6	11	391	020		06	00	058						
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ENTERED
FEB 03 1998
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (JNB)

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	020		08	00	058						
4	04	391	020		06	00	058						
5	04	301	021		02	00	058						
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JAN 22 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

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Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	391	020		08	00	058						
2	26	391	020		08	00	058						
3	27	391	020		08	00	058						
4	28	391	020		08	00	058						
5	29	391	020		08	00	058						
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ENTERED
MAR 05 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
GXB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	3011	009		08	00	058						
2	19	3911	020		08	00	058						
3	20	3911	020		08	00	058						
4	21	3911	020		08	00	058						
5	22	3911	020		08	00	058						
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ENTERED
MAR 05 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
GNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	020		08	00	058						
2	12	391	020		08	00	058						
3	13	391	020		08	00	058						
4	14	391	020		08	00	058						
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MAR 05 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
HRB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	020		08	00	058						
2	05	391	020		08	00	058						
3	06	391	020		08	00	058						
4	07	391	020		08	00	058						
5	08	391	020		06	00	058						
6	08	241	021		02	00	058						
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ENTERED
MAR 05 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (NLB)

ODH Form 4

6

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	3901	003		08	00	058						
2	23	3911	020		08	00	058						
3	24	3911	020		08	00	058						
4	25	3911	020		08	00	058						
5	26	3911	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (NLB)

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	301	009		08	00	058						
2	16	391	020		08	00	058						
3	17	391	020		08	00	058						
4	18	391	020		08	00	058						
5	19	391	020		08	00	058						
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ENTERED
APR 07 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

7

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020		08	00	058						
2	09	241	021		02	00	058						
3	09	301	010		06	00	058						
4	10	391	020		08	00	058						
5	11	391	020		08	00	058						
6	12	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNE

ODH Form 4

6

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	020		08	00	058						
4	04	391	020		08	00	058						
5	05	391	020		08	00	058						
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ENTERED
MAR 19 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JAN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	020		08	00	058						
2	30	391	020		08	00	058						
3	31	391	020		08	00	058						
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ENTERED
JUN 07 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (JNB)

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	020		08	00	058						
2	23	391	020		08	00	058						
3	24	391	020		08	00	058						
4	25	391	020		08	00	058						
5	26	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
4NB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	39 1	020		08	00	058						
2	16	39 1	020		08	00	058						
3	17	39 1	020		08	00	058						
4	18	39 1	020		08	00	058						
5	19	30 1	002		08	00	058						
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ENTERED
JUN 23 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNA

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	021		08	00	058						
2	09	391	021		08	00	058						
3	10	391	021		08	00	058						
4	11	391	021		08	00	058						
5	12	391	010		02	00	058						
6	12	391	020		06	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNS

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 97

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	020		08	00	058						
4	04	391	020		08	00	058						
5	05	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (JNB)

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 97

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	020		08	00	058						
2	27	391	020		08	00	058						
3	28	391	020		08	00	058						
4	29	391	020		08	00	058						
5	30	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jani Ann Nichols NLB

ODH Form

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Month 04 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	391	020		08	00	058						
2	20	391	020		08	00	058						
3	21	391	020		08	00	058						
4	22	391	020		08	00	058						
5	23	301	002		08	00	058						
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ENTERED
JUL 02 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

OLH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	39 1	020		08	00	058						
2	13	39 1	020		08	00	058						
3	14	39 1	010		02	20	058						
4	14	39 1	021		05	40	058						
5	15	39 1	021		08	00	058						
6	16	39 1	021		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	020		08	00	058						
2	06	391	020		08	00	058						
3	07	391	020		08	00	058						
4	08	391	020		08	00	058						
5	09	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
UNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		03	00	058						
2	01	391	021		05	00	058						
3	02	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (NB)

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		08	00	058						
2	25	391	020		08	00	058						
3	26	391	020		08	00	058						
4	27	391	020		08	00	058						
5	28	391	020		08	00	058						
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ENTERED
SEP 22 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	020		08	00	058						
2	18	391	010		02	40	058						
3	18	391	020		05	20	058						
4	19	391	010		02	20	058						
5	19	391	020		05	40	058						
6	20	391	020		08	00	058						
7	21	391	020		08	00	058						
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ENTERED
AUG 17 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	010		02	40	058						
2	10	391	021		05	20	058						
3	11	391	010		00	40	058						
4	11	391	021		07	20	058						
5	12	391	010		02	00	058						
6	12	391	021		06	00	058						
7	13	391	020		08	00	058						
8	14	391	021		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [signature]

OCH-Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	391	010		01	20	058						
2	03	391	021		06	40	058						
3	04	391	010		01	00	058						
4	04	391	021		07	00	058						
5	05	391	020		08	00	058						
6	06	391	020		08	00	058						
7	07	391	020		08	00	058						
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ENTERED
SEP 23 1999
T&E EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
CMB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	391	020		08	00	058						
2	29	391	020		08	00	058						
3	30	391	010		01	00	058						
4	30	391	020		07	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	020		08	00	058						
2	22	391	020		08	00	058						
3	23	391	020		08	00	058						
4	24	391	020		08	00	058						
5	25	391	010		01	40	058						
6	25	391	020		06	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	020		08	00	058						
2	15	391	020		08	00	058						
3	16	391	020		08	00	058						
4	17	391	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols (JAN)

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	020		08	00	058						
2	08	391	020		08	00	058						
3	09	391	020		08	00	058						
4	10	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

ODH Form 4

5

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols NLB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	020		08	00	058						
2	27	391	020		08	00	058						
3	28	391	020		08	00	058						
4	29	391	021		08	00	058						
5	30	391	020		04	00	058						
6	30	391	021		04	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	391	020		08	00	058						
2	20	391	020		08	00	058						
3	21	391	020		08	00	058						
4	22	391	020		08	00	058						
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ENTERED
OCT 25 1999

I certify that these statements are correct and that hours for each work period are accurate.

TIME & EFFORT

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
NCB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	391	020		08	00	058						
2	13	391	020		08	00	058						
3	14	391	020		08	00	058						
4	15	391	020		07	00	058						
5	15	391	010		01	00	058						
6	16	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols GLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols YKB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	391	020		08	00	058						
2	31	391	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols GNB

OSDH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	020		05	00	058						
2	23	391	021		03	00	058						
3	24	391	020		06	00	058						
4	24	391	021		02	00	058						
5	25	391	020		08	00	058						
6	26	391	020		06	00	058						
7	26	391	021		02	00	058						
8	27	391	021		02	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
JAN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	39 1	020		08	00	058						
2	17	39 1	020		08	00	058						
3	18	39 1	020		04	00	058						
4	18	39 1	021		04	00	058						
5	19	39 1	020		08	00	058						
6	20	39 1	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MD

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		08	00	058						
2	10	391	020		08	00	058						
3	11	391	020		08	00	058						
4	12	391	020		08	00	058						
5	13	391	021		02	00	058						
6	13	391	020		06	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
MB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		08	00	058						
2	03	391	020		08	00	058						
3	04	391	020		08	00	058						
4	05	391	010		02	40	058						
5	05	391	021		05	20	058						
6	06	391	020		08	00	058						
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ENTERED
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols GNB

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	3911	021		06	00	058						
2	01	3911	020		02	00	058						
3	02	3911	020		08	00	058						
4	03	3911	021		06	00	058						
5	03	3911	020		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	209		08	00	058						
2	07	391	020		08	00	058						
3	08	391	020		08	00	058						
4	09	391	020		08	00	058						
5	10	391	021		05	00	058						
6	10	391	010		03	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	020		08	00	058						
2	14	391	020		08	00	058						
3	15	391	020		06	00	058						
4	15	391	021		02	00	058						
5	16	391	020		08	00	058						
6	17	391	021		04	00	058						
7	17	391	020		04	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		08	00	058						
2	21	391	020		08	00	058						
3	22	391	020		08	00	058						
4	23	391	010		02	00	058						
5	23	391	021		06	00	058						
6	24	391	020		05	00	058						
7	24	391	021		01	00	058						
8	24	238	021		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols GNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	3911	020		08	00	058						
2	28	3911	010		02	40	058						
3	28	3911	021		05	20	058						
4	29	3911	021		02	00	058						
5	29	3911	010		06	00	058						
6	30	3911	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

OOH Form 4

17

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee [redacted]

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	266	020		05	00	058						
2	16	241	020		01	00	058						
3	16	275	020		01	00	058						
4	16	340	020		01	00	058						
5	17	241	020		07	00	058						
6	17	301	003		01	00	058						
7	18	241	020		08	00	058						
8	19	266	020		02	00	058						
9	19	241	020		02	00	058						
10	19	340	020		02	00	058						
11	19	270	020		02	00	058						
12	20	391	021		01	00	058						
13	20	241	021		02	00	058						
14	20	240	021		03	00	058						
15	20	266	021		01	00	058						
16	20	201	021		01	00	058						
17													
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DEC 30 1998

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [redacted]

Supervisor's Signature Jane Ann Nichols MB

12

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee [redacted]

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	266	020		06	00	058						
2	02	340	020		01	00	058						
3	02	275	020		01	00	058						
4	03	241	020		08	00	058						
5	04	241	020		08	00	058						
6	05	266	020		06	00	058						
7	05	340	020		01	00	058						
8	05	241	020		01	00	058						
9	06	301	010		01	00	058						
10	06	301	021		03	00	058						
11	06	391	021		04	00	058						
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DEC 09 1998
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [redacted]

Supervisor's Signature Jane Ann Nichols UNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee [redacted]

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 98

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	270	020		02	00	058						
2	07	266	020		02	00	058						
3	07	241	020		02	00	058						
4	07	340	020		02	00	058						
5	08	241	020		08	00	058						
6	09	241	020		08	00	058						
7	10	266	020		02	00	058						
8	10	241	020		02	00	058						
9	10	340	020		02	00	058						
10	10	270	020		02	00	058						
11	11	266	021		01	00	058						
12	11	241	021		01	00	058						
13	11	301	021		04	00	058						
14	11	374	021		01	00	058						
15	11	391	021		01	00	058						
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FEB 03 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [redacted]

Supervisor's Signature Jane Ann Nichols JANB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Lisa Williams, RN

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	266	020		03	00	058						
2	16	241	020		03	00	058						
3	16	340	020		01	00	058						
4	16	270	020		01	00	058						
5	17	266	020		02	00	058						
6	17	241	020		02	00	058						
7	17	270	020		02	00	058						
8	17	275	020		02	00	058						
9	18	266	020		04	00	058						
10	18	241	020		04	00	058						
11	19	266	020		03	00	058						
12	19	241	020		02	00	058						
13	19	340	020		01	00	058						
14	19	391	020		01	00	058						
15	19	270	020		01	00	058						
16	20	340	020		03	00	058						
17	20	266	020		03	00	058						
18	20	241	020		02	00	058						

ENTERED
NOV 04 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Lisa Williams, RN

Supervisor's Signature Jane Ann Nichols MD

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Month [illegible] Year [illegible]

Employee [illegible]

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	266	020		03	00	058						
2	23	241	020		03	00	058						
3	23	340	020		01	00	058						
4	23	270	020		01	00	058						
5	24	241	020		06	00	058						
6	24	266	020		02	00	058						
7	25	241	020		08	00	058						
8	26	266	020		02	00	058						
9	26	241	020		02	00	058						
10	26	340	020		02	00	058						
11	26	270	020		02	00	058						
12	27	391	020		04	00	058						
13	27	340	020		04	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [illegible]

Supervisor's Signature [illegible] MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Lori Williams, RN

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	021		04	00	058						
2	01	241	020		04	00	058						
3	02	266	020		02	00	058						
4	02	241	020		02	00	058						
5	02	340	020		02	00	058						
6	02	275	020		02	00	058						
7	03	301	002		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Lori Williams, RN

Supervisor's Signature Jane Ann Nichols CNA

ODH Form 4

	[redacted]				TOTAL			
	ON-SITE SALARY	ON-SITE FRINGE	OFF-SITE SALARY	OFF-SITE FRINGE	ON-SITE SALARY	ONSITE FRINGE	OFF-SITE SALARY	OFF-SITE FRINGE
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	-	-	47.14	15.38	-	-	193.53	76.94
NOVEMBER	0.95	0.28	257.99	82.57	7.47	2.51	1,143.75	455.10
DECEMBER	-	-	372.31	117.71	-	-	1,530.74	603.56
JANUARY 99	13.42	3.54	365.99	114.27	74.95	24.15	1,740.18	668.24
FEBRUARY	11.95	3.54	250.77	76.95	94.87	29.16	1,606.02	626.11
MARCH	12.01	3.53	291.61	91.39	87.39	26.83	2,514.69	814.31
APRIL	5.49	1.87	321.42	98.88	50.76	15.67	2,566.73	829.63
MAY	12.53	3.83	400.94	127.23	103.00	31.79	4,556.99	1,348.25
JUNE	3.99	1.16	352.25	107.84	29.13	8.94	3,392.34	1,059.49
JULY	3.30	0.90	302.14	84.31	28.93	8.13	3,065.19	881.97
AUGUST	3.30	0.90	302.14	84.31	316.87	77.64	3,399.37	970.98
SEPTEMBER	-	-	411.96	115.22	-	-	4,466.41	1,204.37
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	[redacted]				793.37	224.62	30,206.94	9,538.94

Adjustments to TE005 Report
9/29/1998 to 9/28/1999

The following are costs for which there are no supporting documents:

		Total Hours	Total Cost	Per Hour Rate	Hours	Cost Adjustment
1	Byrd, L.	7.00	195.93	27.99	(7.00)	**(195.93)**
2	McBride, J.	0.33	2.21	6.70	(0.33)	**(2.21)**
3	Nichols, J	138.35	4,769.05	34.47	(3.00)	**(103.41)**
4	Ronck, S.	8.00	340.44	42.56	(8.00)	**(340.44)**

The following are costs in addition to those shown on the TE005:

5	Hicks, T.	4.33	90.89	20.99	2.00	**41.98**
6	Waldron, S.	1,649.67	27,359.06	16.58	56.00	**928.74**
7	Williams, K.	13.00	325.62	25.05	2.00	**50.10**

Adjustment Total **$ 378.83**

FEES

9/29/1998 to 9/28/1999

Claims	-
PROGCOST - Fees	373.90
Total Fees	$ 373.90

PERSONAL IDENTIFIER(S) REDACTED

FILENAME: OTTAWA CO. LEAD POISON PREV.

Prepared By: GDS
12-23-1999

TIME AND EFFORT
COST ACCUMULATION SCHEDULE

GRANT NAME: CDC\CONDUCT SITE-SPECIFIC ACTIVITIES
GRANT NUMBER: U50/ATU686520-01
BUDGET PERIOD: 09/29/98 TO 09/28/99
PGM CODE : 391

	== PROGCOST ==				== 244 OTHER ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	2.89	3.43	-	19.74	-	-	-	-
NOVEMBER	17.50	33.13	-	155.18	-	-	-	-
DECEMBER	23.82	44.75	-	179.68	-	-	-	-
JANUARY 99	38.25	38.09	-	182.94	-	-	-	-
FEBRUARY	25.67	29.17	-	154.37	-	-	-	-
MARCH	40.96	42.85	-	212.25	-	-	-	-
APRIL	32.19	46.20	-	216.33	-	-	-	-
MAY	29.01	45.17	-	303.67	-	-	-	-
JUNE	38.18	39.55	-	386.62	-	-	-	-
JULY	20.41	48.85	-	116.28	-	-	-	-
AUGUST	32.43	51.31	-	289.15	-	-	-	-
SEPTEMBER	31.66	39.82	-	480.50	-	-	-	-
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	354.97	465.22	-	2,886.80	-	-	-	-

	== 301 OTHER ==				== TOTAL ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	0.52	0.68	-	3.79	3.21	4.09	-	23.53
NOVEMBER	2.46	4.85	-	21.79	19.96	37.78	-	176.97
DECEMBER	3.00	5.62	-	22.57	26.82	50.37	-	202.25
JANUARY 99	5.46	5.17	-	27.84	43.71	41.26	-	220.58
FEBRUARY	3.43	3.88	-	20.48	29.30	33.03	-	174.85
MARCH	4.88	4.75	-	23.63	45.84	47.60	-	235.88
APRIL	3.83	5.73	-	25.74	36.02	53.85	-	242.07
MAY	3.14	4.88	-	32.83	32.15	50.06	-	336.50
JUNE	4.55	4.59	-	42.58	43.73	44.14	-	409.18
JULY	2.14	5.24	-	12.19	22.56	55.19	-	128.48
AUGUST	3.19	5.05	-	28.48	35.62	56.36	-	317.61
SEPTEMBER	3.53	4.44	-	53.64	35.19	44.26	-	534.14
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	36.83	54.85	-	315.40	[illegible]	[illegible]	-	[illegible]

	TOTAL NON-PAYROLL
JULY 98	-
AUGUST	-
SEPTEMBER	-
OCTOBER	30.83
NOVEMBER	234.71
DECEMBER	278.52
JANUARY 99	305.56
FEBRUARY	237.18
MARCH	326.82
APRIL	332.02
MAY	418.01
JUNE	497.05
JULY	208.22
AUGUST	408.59
SEPTEMBER	613.59
OCTOBER	-
NOVEMBER	-
DECEMBER	-
TOTAL	3,893.07

TRAVEL

9/29/1998 to 9/28/1999

Claims	1,497.30
PROGCOST - Travel	517.87
Total Travel	$ 2,015.17

PERSONAL IDENTIFIER(S) REDACTED

Ottawa 93

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		067715

FOR AGENCY USE: BT910 NW97 DU14B MC

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
DU035	4000	2111	~~93.1740000~~	68.51
		2114	932000000	4050

OSF - Audited By:

TOTAL AMOUNT $ 73.01

FOR $ 73.01 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Hea

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: ____

Claimant Signature

WARR NUM: 7254086
WARR DATE: 09/23/1999
CLAIM NO: 067715

OFFICIAL DUTY STATION: Miami, OK

NATURE OF OFFICIAL BUSINESS: 391 - Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1999 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Picher-Miami	08	03	20	26							
Miami-Vicinity		04	-	6							
Miami-Tulsa-Miami		05	89	8							
Miami-COmmerce-Miami		06	8								
Miami-Vicinity		12	-	6							
Miami-Vicinity		18	-	8							
Miami-COmmerce-Miami		19	8								
Miami-Vicinity		23	-	8							
Miami-Commerce-Miami		24	8								
Miami-Vicinity		26	-	6							
Miami-Picher-Miami		30	20								
TOTALS			153	68							
			221		TOTAL MILES @		.31		PER MILE =		68.51

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: Turnpike TOLLS: 4.50	
RENTAL CAR:	PARKING:	TOTAL MISC. 4.50
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 73.01

I, Susan Waldron ..... the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me Sept. 1, 1999

My Commission expires 5-27 2002

Janie Linn
Notary Public (or Clerk or Judge)

Jane Ann Nichols
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Actor [signature]
Chief, Financial Ma...

Agency's Approving Officer SEP 10 1999

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Title

Agency, Bd., or Div. Use

(OSF FORM 00)

OSF REJECTION NOTICE

This rejection notice MUST BE RETURNED with claim.

AGENCY NO. 340 CLAIM NO. 7715 ORDER NO.

Date 9-16-99 Phone: 521- 6187 Pre-audited by: Jeannette

01 OVERDRAWN	07 FUND	13 PAYEE	19 AGENCY REQUEST	25 CLAIMANT'S INIT.
02 CHANGE ORDER	08 ACCOUNT	14 NOTARY	20 LOCAL PROJECT	26 VENDOR SNAG
03 ENCUMB. REQ'D.	09 SUB-ACTIVITY	15 CALCULATION	21 PER DIEM	X 27 OTHER
04 APPRVG OFFICER	10 OBJECT CODE	16 FISCAL EXP	22 LODGING	
05 CASH	11 INV SIGNATURE	17 FUNDS LAPSED	23 TRANSPORTATION	** ORDER NUMBER
06 ALLOTMENT	12 INV MISSING	18 FEI#/SS#	24 TRAVEL MISC.	** CLAIM NUMBER

Additional remarks: System shows CFDA# 93200000 for this claim

Agency comments (optional):

Miami, OK | 391 - Lead Project

OTTOWA (R5)

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
46[illegible]	340		015375

FOR AGENCY USE: BT90 NW99 OTTAB

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO X
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES X
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
[illegible]	[illegible]	2111	93.1740000	$52.70

OSF - Audited By:

TOTAL AMOUNT $ 52.70

FOR $ 52.70 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of He

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7554459
WARR DATE: 12/03/1999
CLAIM NO: 015375

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391 LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 99 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI-COMMERCE-MIAMI	10	04	08								
MIAMI-WYANDOTTE-MIAMI	10	05	30	02							
MIAMI-COMMERCE-MIAMI	10	12	08								
MIAMI VICINITY	10	13		06							
MIAMI-COMMERCE-MIAMI	10	18	08								
MIAMI VICINITY	10	20		06							
MIAMI-AFTON-MIAMI	10	25	30								
MIAMI-PICHER-MIAMI	10	26	20								
MIAMI-PICHER-MIAMI	10	27	20	10							
MIAMI-COMMERCE-MIAMI	10	28	16								
MIAMI VICINITTY	10	29		06							
			140	30							
TOTALS			140	~~170~~ 170	170 TOTAL MILES @ .31					PER MILE =	$52.70

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $52.70

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 11-1, 19 99

My Commission expires 5-27 - 2002, 19

Janice Linn
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Officer

Chief, Financial Management
Title
Agency, Bd., or Div. Use

NOV 2 3 1999
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19 (Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		931247

FOR AGENCY USE: BT99 NW97 011748

CLAIM OF: Ottawa 48 Susan Waldron

S.S. PERSONAL IDENTIFIER(S) REDACTED

FOR 643.10

$ ~~644.90~~ AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

IS CAR GOV. OWNED? YES ___ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42000	2111	932000000	46.80
		2121		53.30
		2123		104.00
		2126		410.40
		2125		28.60

OSF - Audited By:

TOTAL AMOUNT $ 643.90

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7910007

WARR DATE: 05\04\1999

CLAIM NO: 931247

OFFICIAL DUTY STATION: Miami, OK

NATURE OF OFFICIAL BUSINESS: Lead Project (391) Mtgs

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 99 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	
Miami-Vicinity	03	2		12								
Miami-Commerce-Miami		5	8		5900							
Fairland* - Tulsa (Atlanta**)		7	82		~~6:30~~			2		104.00		
Tulsa-Fairland*		11	82			11:00	4	~~16~~		~~123.50~~	410.40	
Fairland*-Grove-Miami		12	38									
Miami-Jay-Miami		23	72									
Miami-COmmerce-Miami		25	8									
Miami-Vicinity		29		6								
*Travel from home (Fairland) closerthhan home base												
**Air travel to Atlanta paid by OSDH												
TOTALS			290	18			4	2		104.00	410.40	514.40

308 TOTAL MILES @ .325 PER MILE = 100.10

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

Mtg began 0900 - 3/8 - * to comply with the Rule.
and 1930 - 3/10

AGENCY DIRECT PURCHASE X (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED): ATSDR Partners Conf.	$25.00
SHUTTLE:	TELEPHONE: TOLLS: Turnpike	$3.60
RENTAL CAR:	PARKING: TOTAL MISC.	28.60
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP.	
	TOTAL AMOUNT CLAIMED	~~662.60~~ 643.10

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 4-9, 1999

My Commission expires 5-27, 2002

Janice Linn
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act of

Chief, Financial Management

Agency's Approving Officer

APR 28 1999

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Title

Agency, Bd., or Div. Use

Sheraton Colony Square
HOTEL
MIDTOWN ATLANTA

GUEST
Ms Susan Waldron
Agency For Toxic Sub & Dise
PERSONAL IDENTIFIER(S) REDACTED
United States
TOXIC

ROOM 923
RATE 90.00
NO. PPL. 1
FOLIO 96371 EX-A
PAGE 1
ARRIVE 07-MAR-99 14:07
DEPART 11-MAR-99
PAYMENT VM

TRAVEL AGENT CHARGE TO

DATE	REFERENCE	DESCRIPTION	CHARGES/CREDITS
07-MAR-99	RT923	Room Charge G\Government	90.00
07-MAR-99	RT923	Sales Tax	6.30
07-MAR-99	RT923	Occupancy Tax	6.30
08-MAR-99	RT923	Room Charge G\Government	90.00
08-MAR-99	RT923	Sales Tax	6.30
08-MAR-99	RT923	Occupancy Tax	6.30
09-MAR-99	RT923	Room Charge G\Government	90.00
09-MAR-99	RT923	Sales Tax	6.30
09-MAR-99	RT923	Occupancy Tax	6.30
10-MAR-99	RT923	Room Charge G\Government	90.00
10-MAR-99	RT923	Sales Tax	6.30
10-MAR-99	RT923	Occupancy Tax	6.30
		Total-Due	410.40

102.60 x 4 = 410.40

EXPENSE REPORT SUMMARY

Date	Rm & Tax	FD&Bev	Phone	Park	Other	Total	Payment
07-MAR-99	102.60	0.00	0.00	0.00	0.00	102.60	0.00
08-MAR-99	102.60	0.00	0.00	0.00	0.00	102.60	0.00
09-MAR-99	102.60	0.00	0.00	0.00	0.00	102.60	0.00
10-MAR-99	102.60	0.00	0.00	0.00	0.00	102.60	0.00
Total	410.40	0.00	0.00	0.00	0.00	410.40	0.00

Balance Due -00-

Pd by Visa

I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

SIGNATURE

As a STARWOOD PREFERRED GUEST member, you have earned at least 720 points for your visit. STARWOOD HOTELS & RESORTS offer more staying power!

Ms Susan Waldron		ROOM	DEPART	AGENT
FOLIO 96371	07-MAR-99	923		

Sheraton Colony Square
HOTEL
MIDTOWN ATLANTA

APR 22 1999

LOCAL HEALTH ADM.-FINANCE

1999 ATSDR Partners in Public Health Meeting

"Facing Conflict and Developing Partnerships for a Healthier World"

Sheraton Colony Square Hotel, Atlanta, Georgia

March 8-10, 1999

Hotel Information

All guests will be staying at the **Sheraton Colony Square Hotel**, 188 14th Street, NE, Atlanta, Georgia 30361. Please register with the hotel directly by calling **800-422-7895**, and be sure to mention that you are attending **The Partners Meeting** in order to receive the specially-negotiated room rate of $90.00 plus tax. If your organization is tax-exempt, you must bring with you a tax-exempt form in order to avoid paying taxes on your room. For those of you who wish to check in early or stay after the conference has concluded, this room rate is good for arrival **March 7 through March 11**. The hotel recently informed us that it is sold out for Saturday night, March 6. However, you can get on a waiting list for that night by calling **Jonathan Phillips at 800-780-8872, ext. 223**. Please make your reservations now for March 7 and beyond. The deadline to make your room reservation is **February 8, 1999. Check in time is after 3:00 p.m.; check out time is before noon.**

If you expect to arrive after 6:00 p.m., you will need to guarantee your room reservation with a credit card, or your reservation will automatically be canceled. To avoid any unforeseen circumstances, it is strongly suggested that you call and reserve your hotel room with a credit card, regardless of your expected arrival time. If you need to cancel or make changes to your hotel reservations, please contact the hotel immediately.

Ground Transportation:

There are several options available for transportation to and from the Sheraton Colony Square Hotel. First, go to the "Ground Transportation Area" of Hartsfield International Airport. From there the options available for transportation include **MARTA** (Metropolitan Atlanta Rapid Transit Authority - Atlanta's transit system), the **Atlanta Airport Shuttle**, or a local **taxi** cab.

- **Atlanta Airport Shuttle**, a local ground transportation system, services the hotel. At the airport, follow the signs for public ground transportation. The shuttle is on the first service island outside public ground transportation (stalls 9-13). You must check in at the booth on the service island, which is approximately 20 yards outside of the baggage claim doors. Fares for the shuttle are $10 one-way and $17 round-trip. If you have any questions regarding this service, call Atlanta Airport Shuttle at (404) 524-3400.

Spring Health Education Training Module Agenda

Thursday, March 11, 1999

8:00-8:30	Welcome
8:30-9:30	Introductions/perceptions
9:30-10:00	Learning styles
10:00-10:15	Break
10:15-11:30	Health education theory and case examples Participants will be able to describe two health education theories and describe two instances in which they could be used.
11:30-12:30	Lunch
12:30-1:30	Workgroups review case study
1:30-2:30	Needs assessment Participants will be able to define needs assessment and describe the rationale for conducting a needs assessment. Participants will be able to determine and use the most appropriate needs assessment methodology or methodologies for a site.
2:30-2:45	Break
2:45-3:30	Workgroups conduct a needs assessment
3:30-4:30	Introduction to developing and testing easy to read, culturally sensitive materials Participants will be able to name three aspects to consider when designing a communication tool for a specified audience.
4:30-5:00	Review of day

Friday, March 12,1999

8:00-8:30	Review
8:30-9:45	Evaluating health education activities Participants will be able to differentiate between, formative, process, outcome, and impact evaluation. Participants will be able to describe a strength and weakness of two different evaluation tools.
9:45-10:00	Break
10:00-11:15	Workgroups develop presentations
11:15-11:30	Evaluation
11:30-12:30	Lunch
12:30-2:30	Presentations
2:30-3:00	Wrap-up

Statement for Awarding Continuing Education Unit Credit (Include here and also in course announcement/brochure) This program has been structured following the International Association for Continuing Education and Training (IACET) Criteria and Guidelines and therefore is awarding Continuing Education Units (CEUs). The Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR) will award 1.3 CEUs to each participant who successfully completes this training. The CEU is a nationally recognized unit designed to provide a record of an individual's continuing education accomplishments.

Monday, March 8 (cont'd)

3:30 p.m. - 5:00 p.m.

A *Use of Modeling in Assessments* — Ballroom South

B *Exit Activities: How do we know when?* — Ballroom North

C *607 Health Studies* — Sherwood Room

D *Methamphetamine Lake Roundtable* — Brookwood Room

E *Enhancement of Local Public Health Department Participation in Brownfields Decisions and Actions* — Georgia Room

5:30 p.m. - 6:30 p.m.

Special Session *Issues and Answers* — Habersham Room

Tuesday, March 9, 1999

8:00 a.m. - 9:00 a.m.

General Session *Poster Session: Show & Tell* — Ballroom Foyer

9:00 a.m. - 10:15 p.m.

A *Reporting Q & A with NCEH/ATSDR and DHEP Division Directors* — Ballroom South

B *Developing Web Sites: Review Model* — Sherwood Room

C *Brownfields: How to Develop a Comprehensive Training Program* — Georgia Room

D *Cancer Cluster Investigations* — Sherwood Room

10:45 a.m. - 12:00 p.m.

General Session *Recent Advances in Theory and Practice of Risk Communication, Part I* — Ballroom North

Keynote Speaker: Dr. Vincent T. Covello

12:30 p.m. - 1:30 p.m.

General Session *Brown Bag It with Dr. Covello* — Ballroom North

1:30 p.m. - 2:45 p.m.

Session A *Fish Advisories and Education* — Georgia Room

Session B *DHS Showcase: Highlights of Current Activities* — Ballroom North

Session C *Working with the Press* — Sherwood Room

Session D *State Program Evaluation* — Ballroom South

3:00 p.m. - 4:00 p.m.

General Session Recent *Advances in Theory and Practice of Risk Communication, Part 2* — Ballroom North

Keynote Speaker: Dr. Vincent T. Covello

4:15 p.m. - 5:30 p.m.

A *Tribal Subgroup (**new 3:15**)* — Ansley Room

B *National Organizations Subgroup* — Ardmore Room

C *ATSDR and Minority Health in the States* — Ballroom North

D *Health Educators Subgroup* — Sherwood Room

E *Health Assessor Subgroup* — Ballroom South

F *Epidemiologist Subgroup* — Brookwood Room

*7:00 p.m. - 10:00 p.m.

"Talent/No Talent" Talent Show & Presentation of Eddie Award — Crown Room, Top Floor

*Start time has changed from 8:00 p.m. to 7:00 p.m.

Wednesday, March 10, 1999

9:00 a.m. - 10:15 a.m.

A *Overview of the Office of Urban Affairs: A Strategic Approach* — Ansley Room

B *Manufactured Gas Plants: Issues & Remediation Strategies* — Brookwood Room

C *DHAC Showcase: Highlights of Current Activities* — Ballroom North

D *PGO Grants, Grins & Groans: Application Pointers, Funding Process & Schedules* — Ballroom South

10:45 a.m. - 12:00 p.m.

A *Odors... Indoor... outdoor* — Ballroom North

B *States' Perspective on Meeting the Needs Of Site Managers, Communities and ATSDR* — Ballroom South

C *Division of Toxicology and Public Health Practice: A Roundtable Discussion* — Georgia Room

D *Departments of Defense and Energy Environmental and Public Health Programs: Meeting the Public Health Challenge* — Ansley Room

1:30 p.m. - 2:30 p.m.

A *Environmental Health Interventions and Pediatric Environmental Health Specialty Units* — Brookwood Room

B *Exposure Investigation Case Studies* — Georgia Room

C *Evaluation Program and Activities* — Ansley Room

D *Children's Health: Issues, Activities, and Partnerships* — Ballroom North

ATSDR

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

RECEIVED
FEB 23 A 10:50
FINANCIAL MANAGEMENT

1999 ATSDR Partners in Public Health Meeting

March 8-10, 1999

Agenda At-A-Glance

Facing Conflict and Developing Partnerships for a Healthier World

Co-Sponsors

[redacted]

Partners

Monday, March 8, 1999

9:00 a.m. - 11:00 a.m.

General Session — *Opening Welcome Session* — Ballroom North

11:00 a.m. - 12:15 p.m.

A *Mercury Issues* — Ballroom North

B *National Organizations Showcase: Highlights of Current Activities* — Georgia Room

C *Working in Teams: The Good, The Bad and the Ugly* — Brookwood Room

D *Brownfields: Responding To Health Education/Community Involvement Issues* — Sherwood Room

E *Congress and Superfund* — Ballroom South

1:30 p.m. - 3:00 p.m.

A *Tribal Showcase: Highlights of Current Activities* — Sherwood Room

B *Weight of Evidence - Making the Hard Call* — Ballroom North

C *DHEP Showcase: Medical Monitoring and Psychological Effects* — Georgia Room

D *Community Involvement - Beyond the Basics* — Ballroom South

E *Brownfields: Technical Issues (Residential Reuse, Risk-Based Corrective Action)* — Brookwood Room

February 12, 1999 **Invoice** 811824

Make Checks Payable To:

National Environmental Health Association

720 S. Colorado Boulevard, #970, S. Tower, Denver, CO 80246

Telephone (303) 756-9090 • http:\\www.neha.org • email: staff@neha.org

FIN - 84-0469910

☐ Address Change Requested

Please make change in address below.

Susan Waldron
Ottawa Co Health Dept

PERSONAL IDENTIFIER(S) REDACTED

Payments are due 30 days after service is rendered. A 5% service charge will be added to all open accounts after 60 days. For your convenience, we accept Mastercard, Visa and Amer. Express. Please call ext. 308 if you have questions on your invoice.

RETURN ENTIRE ORIGINAL WITH PAYMENT

Description	Amount
ATSDR 1999 Partners in Public Health	$ 25.00
Total charges	$ 25.00
02/12/99 American Express	$ 25.00

PERSONAL IDENTIFIER(S) REDACTED

Balance due [redacted]

CONFIRMATION

811824 February 12, 1999 Susan Waldron Total Enclosed $

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Reject Number: 2344

Please Return With Claim

Division: Local Health

Employee: WALDRON (Last Name) SUSAN (First Name) (MI)

Travel for the Month of: March

Claim Amount: 662.60

Please provide information indicated by check box(es) below:

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel:
- ☐ Verify Funding Information
  - Fund: [redacted]
  - Account:
  - Agency:
  - Program:
  - Other:

Please Complete The Following:

- ☐ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim!
- ☐ Agency, Board, or Divisional Use
- ☐ SSN or FEI #
- ☐ License #

TRAVEL

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIPTS

- ☑ Designated Hotel documentation required.
- ☐ Lodging Receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt. Statement required on face of claim indicating number of meals included and amount or "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

MISCELLANEOUS

- ☐ Gas Mileage Required
- ☐ Amount Exceeds Allotment

Other Remarks & Comments:

Financial Management Reviewed By: Ruby Sherwan

Date: 4/19/99

APR 19 1999

HEALTH

Waldron, Susan A.

From: Waldron, Susan A.
Sent: Wednesday, February 17, 1999 10:52 AM
To: Powell, Nancy L.
Subject: RE: Susan Waldron - OOS

Yes, it's great – I'm so sorry for the problem, I can't apologize enough – I used to live in Oklahoma City, and I guess I thought I still did!! THANKS for your help!

From: Powell, Nancy L.
Sent: Tuesday, February 16, 1999 4:14 PM
To: Waldron, Susan A.
Cc: Wilson, Linda; Cadaret, Ken
Subject: FW: Susan Waldron - OOS

Susan, is this schedule O.K.?

From: Murrell, Elvia
Sent: Tuesday, February 16, 1999 4:04 PM
To: Powell, Nancy L.
Subject: RE: Susan Waldron - OOS

Her new schedule:

Leave Tulsa on 3/7 at 8:04a on TWA flight 385
Arrive St Louis at 9:21a
Leave St Louis at 10:24a on TWA flight 518
Arrive Atlanta at 1:02p

Leave Atlanta on 3/11 at 6:48p on TWA flight 570
Arrive St Louis at 7:37p
Leave St Louis at 8:18p on TWA flight 409
Arrive Tulsa at 9:46p

This is a contract flight. I need acceptance of schedule asap so that I can process this request. Thank you.

From: Powell, Nancy L.
Sent: Tuesday, February 16, 1999 12:45 PM
To: Murrell, Elvia
Subject: Susan Waldron - OOS

Elvia, please put a STOP on ordering a ticket for Susan Waldron who "accepted" her schedule as of 2/12/99.

Ken Cadarac (sp) just came in and told me Susan would be e-mailing me "shortly" as she needs to fly out of Tulsa rather than OKC since she's in Ottawa county.

Thank you.

RECEIVED
FEB 11 1999
Financial Health Finance

S013632 CG

OKLAHOMA STATE DEPARTMENT OF HEALTH

INTERSTATE TRAVEL REQUEST/AUTHORIZATION

Control No. _____
Date 2/9/99 PH
Budget Code _____

Susan Waldron-Atlanta - 29899 Elvia 4727

PERSONAL IDENTIFIER(S) REDACTED

DIVISION: MCH (Ottawa County Health Department)

TO BE CHARGED TO: 2/8/16 400BT99 009935NW97 42000 93.200000
ATSDR - Ottawa County - Site Specific (Fund & Account) 0 % (State) 100 % (Federal)

APPLICANT: Susan Waldron POSITION (Title): PHCWIII 00543T

DATE OF DEPARTURE: 3/7/99

NATURE OF TRIP (School, Meeting, Convention, etc.): ~~ATSDR mandatory meeting~~

1999 ATSDR Partners in Public Health (Name) 3/8 thru 3/12/99 (Date) Atlanta, GA. (Location)

MODE OF TRAVEL (Private - Public): Air/public

Ref w/disc

ESTIMATED COST: $ 359.59 (Travel) $ 130.00 (Per diem) 25.00 registration 50.00 ground trans. 360.00 lodging (Other) $ 924.59 (Total)

JUSTIFICATION FOR TRIP: ATSDR Cooperative Agreement Training, required per grant

~~Specifically~~ funded by the grant.

Refundable is $366.00. Discount is $6.41.

DURATION OF TRIP WILL INCLUDE 4 DAYS AT MEETING AND 1 DAYS ENROUTE.

TOTAL OF 5 DAYS.

APPROVED: Susanna Dailey/pw
Service or Office Chief/Division Director

APPROVAL AND TRAVEL AUTHORIZATION

The individual named hereon is authorized to perform official travel as indicated.

J Rhodes MD
Commissioner

2-17-99
Date

OSDH Form No. 81
(Rev. 8/78)

Ottawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		936336 MS MS

FOR AGENCY USE: BT99 NWOA 01140

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X

LICENSE NO. REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42ND	2111	93200000	110.98
		2114		7.20

PERSONAL IDENTIFIER(S)

OSF - Audited By:

TOTAL AMOUNT $ 118.18

FOR $ 118.18 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 8073066
WARR DATE: 06\24\1999
CLAIM NO: 936336

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: 391 LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1999 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
MIAMI-VINITA-MIAMI	05	03	54	04							
MIAMI-WYANDOTTE-MIAMI	05	04	30	02							
MIAMI-COMMERCE-MIAMI	05	06	08								
MIAMI-TULSA-MIAMI	05	10	898	08							
MIAMI-COMMERCE-MIAMI	05	11	08								
MIAMI-JAY-MIAMI	05	12	36	04							
MIAMI-TULSA-MIAMI	05	18	89	08							
MIAMI-VICINITY	05	20		06							
MIAMI-VICINITY	05	25		06							
MIAMI-VICINITY	05	28		06							
			314	44							
TOTALS				358	TOTAL MILES @ .31				PER MILE =		110.98

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS	7.20
RENTAL CAR:	PARKING:	TOTAL MISC	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	118.18

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 6-2 1999

My Commission expires 5-27 1992 Janice Lim
Notary Public (or Clerk or Judge)

Jane Ann Nichols
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act
Chief, Financial Management

Agency's Approving Officer

JUN 18 1999

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

EXPLANATION OF TRAVEL

5-3 TO CRAIG COUNTY HEALTH DEPT TO WORK ON LEAD GRANT
5-4 TO BEARSKIN OFFICE FOR TEAL CAB MEETING
5-6 MEET WITH HUD - MARY HAPPY
5-10 TO MEET WITH KEN, JANE ANN AND TRUDY ON LEAD GRANT
5-11 NEWSLETTER MEETING
5-12 MEET WITH KAREN & GEORGE @ DELAWARE COUNTY HEALTH DEPT.
5 18 MEET WITH LORAINE, KEN,KAREN & LEAD GEAR
5-20 PAINTING ESTIMATE @ SOONER
5-25 HEALTH COALITION MEETING
5-28 MEET WITH DR. FUHEMEISTER RE:HEALTH PROFESSIONAL BROCHURE

OSF Form 19 5/5/97. Ottawa

OSF Form 19 (Revised 4/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		932848

CLAIM OF: SUSAN WALDRON

FOR AGENCY USE: BT 99 NWOA 01174 D

S.S. No.: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____ NO X	00435	42000	2111	93.200000	27.90

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

OSF - Audited By:

TOTAL AMOUNT $27.90

FOR $27.90

AGAINST

Agency, Board, Comm., Dept.: Okla State Dept. of H

ASSIGNMENT

I hereby assign this claim to ____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: ____

Claimant Signature

WARR NUM: 796828

WARR DATE: 05\20\1999

CLAIM NO: 932848

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391 LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 99 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI VICINITY	04	06		06							
MIAMI VICINITY	04	09		04							
MIAMI VICINITY	04	12		06							
MIAMI-COMMERCE-MIAMI	04	13	08								
MIAMI-PICHER-MIAMI	04	14	20	22							
MIAMI VICINITY	04	15		04							
MIAMI VICINITY	04	16		04							
MIAMI-COMMERCE-MIAMI	04	21	08								
MIAMI VICINITY	04	26		04							
MIAMI VICINITY	04	28		04							
TOTALS			36	54			90	TOTAL MILES @	.31	PER MILE =	27.90

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 27.90

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 4-30 1999

My Commission expires 5-27-2000 Janice Sims
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Advisor

Financial Manager

Agency's Approving Officer

MAY 14 1999

Title

Agency, Bd., or Div Use OTTAWA COUNTY HEALTH DEPT. 1830 NORTH ELM MIAMI, OKLAHOMA 74354

OSF Form 19 (Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		931804

FOR AGENCY USE: PT99 NWOA 011748

CLAIM OF: Susan Baldron

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____ NO XX	00935	72000	2111	[illegible]	12.15
			2112	93200000	27.00
			2115		46.35
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	88.50

FOR $ 88.50 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of H

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant Signature

WARR DATE: 05\18\1999

WARR NUM: 795128

CLAIM NO: 951604

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami, OK	Lead Project (3910

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 99 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
Miami-Vinita**	03	31	27		05:00 p.m.					✓	✓
Vinita-Miami	04	01	27			5:30 p.m.	1	12		~~31.25~~ 25.00	46.3
**Rode from Vinita to OKC with coworker Trudy Frost											
District stay at Designated @ $79 + tax											
TOTALS			27 @ .325 = 8.78				1	7			17.15
			27 @ .315 = ~~8.50~~ 8.51 MILES @						.315	PER MILE =	~~11.27~~

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED)		
SHUTTLE:		TELEPHONE:	TOLLS:	
RENTAL CAR:		PARKING	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	94.87

I, Susan Baldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan W. Baldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 5-4-1999

My Commission expires 5-21-2002 Janice Lynn
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Officer

Chief, Financial Management

Agency's Approving Officer

Title

Agency, Bd., or Div. Use

MAY 04 1999
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Turning Point: Building Healthy Communities in Oklahoma through

PARTNERSHIPS

Oklahoma State Department of Health
1000 N.E. 10th St., Oklahoma City, OK 73117-1299 • (405) 271-5601

MEMO • March 10, 1999

TO: Turning Point Partners
FROM: Neil Hann

As mentioned earlier, we are planning a special **Training Session for Turning Point on April 1** from 8:30 a.m. to 4:00 p.m. (registration will begin at 8:00 a.m. with coffee, juice and danish rolls available at 7:45). Originally planned as "evaluation" training, the session has been expanded to include training on an entire community planning process. I believe the session will be extremely valuable and will be of great assistance as we begin working on our public health improvement plans.

The training will be done by Dr. Robert Goodman of Tulane University and Dr. Ken McLeroy of the O.U. College of Public Health. We will be meeting at the **Clarion Meridian Hotel and Convention Center** at 737 S. Meridan (formerly the Holiday Inn West), telephone (405) 942-8511. The hotel is located at the I-40 Merdian exit, just south of the Interstate.

For those out of Oklahoma City, you will need to arrive the evening before (March 31) since we will get started with registration by 8:00 a.m. on April 1. Rooms are available for a rate of $59.00 plus tax. Please mention Turning Point Training when reserving your room and make your hotel room reservations no later than March 24. We will be able to reimburse you for travel including the sleeping room, per diem and mileage. There is no registration fee for this training session.

I encourage each of you to invite several from your local partnerships to attend. We can accommodate up to 35 people for the training, so let potential attendees know as soon as possible, and let us know all who will be attending from the local partnerships. **Please RSVP for the training to Karen Higgins no later than March 24, phone (405) 271-5601 or e-mail, karen@health.state.ok.us.**

Below is a preliminary agenda. I look forward to seeing each of you on April 1. – Neil

7:45 – Coffee, Juice, and Danish Rolls

8:00 – Registration

8:30 – Introductions and Welcome

8:45 – Community History and Description

10:15 – Break

10:30 – Data and Planning Models

Noon – Lunch on your own

1:15 – Community Priorities and Resource Assessment

2:30 – Break

2:45 – Collaboration Strategies

3:45 – Summary and Wrap-up

Late registration stayed in motel 6 at lower rate

Post-it® Fax Note 7671	Date 3/13/99	# of pages ▶ 1
To SUSAN WHIDON	From LINDA McLeroy	
Co./Dept. OTTAWA CHD	Co. Cherokee CHD	
Phone #	Phone # 918 456 0518	
Fax #	Fax # [illegible]	

MOTEL 6 - OKLAHOMA CITY #1128
4200 W I 40
OKLAHOMA CITY, OK. 73108
405/947-6550 FAX 405/947-0970

** GUEST FOLIO **

DATE PRINTED: 04/01/99
PRINTED BY: SD

FOLIO NUMBER: 44306-A
ARRIVAL DATE: 03/31/99
DEPARTURE DATE: 04/01/99

GUEST: SUSAN WALDRON

PERSONAL IDENTIFIER(S) REDACTED

DATE	ROOM	DEPARTMENT	CHARGES	CREDITS
03/31/99	335	CASH		46.35
03/31/99	335	ROOM RENT AUTO AUDIT	41.99	
03/31/99	335	CITY -	0.84	
03/31/99	335	STATE -	3.52	
		Total:	46.35	46.35
		BALANCE DUE:		0.00

GUEST SIGNATURE: _____

MOTEL 6 - OKLAHOMA CITY #1128

12383570

WALDRON (Last)	SUSAN (First)		
Company/Group			
335 (Room)		44306 (Folio #)	2/0 (Adult/Child)
03/31/99 (Arrive)		04/01/99 (Depart)	RACK (Rate Type)
41.99 (Rate/Night)		4.36 (Tax/Night)	46.35 (Total Est. Charge)

Date	Room	Description	Charges	Credits
03/31/99	335	CASH	46.35	46.35

FOR RESERVATIONS NATIONWIDE, CALL 1-800-4-MOTEL 6

NOTICE TO GUEST:

This property is privately owned. Management reserves the right to refuse service to anyone and will not be responsible for the loss of money, jewelry or valuables of any kind.

RATES ARE SUBJECT TO APPLICABLE TAXES AND MAY CHANGE WITHOUT ADVANCE NOTICE

Turning Point: Building Healthy Communities in Oklahoma through

PARTNERSHIPS

Oklahoma State Department of Health
1000 N.E. 10th St., Oklahoma City, OK 73117-1299 • (405) 271-5601

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Below is a preliminary agenda. I look forward to seeing each of you on April 1. – Neil

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8:00 – Registration

8:30 – Introductions and Welcome

8:45 – Community History and Description

10:15 – Break

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Noon – Lunch on your own

1:15 – Community Priorities and Resource Assessment

2:30 – Break

2:45 – Collaboration Strategies

3:45 – Summary and Wrap-up

Late registration stayed in motel 6 at lower rate

Post-it® Fax Note 7671	Date 3/13/99	# of pages ▶ 1
To SUSAN WHIDON	From LINDA MXLeroy	
Co./Dept. OTTAWA CHD	Co. Cherokee CHD	
Phone #	Phone # 918 456-0518	
Fax #	Fax # 918-458-6579	

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Please Return With Claim

Reject Number: 2345

Division: Local Health

Employee: WALDRON (Last Name) SUSAN (First Name) [ ] (MI)

Travel for the Month of: March

Claim Amount: 94.87

Please provide information indicated by check box(es) below.

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel
- ☐ Verify Funding Information

[redacted]

Please Complete The Following:

- ☐ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim
- ☐ Agency, Board, or Divisional Use
- ☐ SSN or FEI #
- ☐ License #

TRAVEL

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIPTS

- ☐ Designated Hotel documentation required.
- ☐ Lodging receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt: Statement required on face of claim indicating number of meals included and amount or: "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

MISCELLANEOUS

- ☐ Map Milage Required
- ☐ Amount Exceeds Allotment

Other Remarks & Comments:

ON THE TIME ENTERING AND ENDING TIME STATUS PLEASE STATE WHETHER AM OR PM. IF SHE LEFT MIAMI AT 5:00 AM ON THE 31ST DID SHE HAVE OTHE BUSINESS IN OKC?

Financial Management Reviewed By: Ruby Sherwan

Date: 4/19/99

OSF Form 19 4/12/11
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		930581

FOR AGENCY USE: BT99 NWOA 01174B

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42000	2111	93.1946000	23.40

IS CAR GOV. OWNED? YES ___ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

OSF - Audited By:

TOTAL AMOUNT $ 23.40

FOR $ 23.40 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of H

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7895338
WARR DATE: 04\28\1999
CLAIM NO: 930581

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami, OK	Lead Project (391)

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 99 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity	02	2		4							
Miami-COmmerce-Miami		3	8								
Miami-Vicinity		10		4							
Miami-Grove-Miami		12	48								
Miami-Commerce-Miami		24	8								
TOTALS			64	8							

72 TOTAL MILES @ .325 PER MILE = 23.40

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.

TOTAL AMOUNT CLAIMED 23.40

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 4 9 1999

My Commission expires 5 27 2002

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Appr.

Financial Management

Agency's Approving Officer

APR 22 1999

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Title

Agency, Bd., or Div. Use

OSF Form 19 4/12/99
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		930577

FOR AGENCY USE: BT99 NWOA 01174B

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

WARR NUM: 7895334
WARR DATE: 04\28\1999
CLAIM NO: 930577

IS CAR GOV. OWNED? YES ___ NO XX
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42000	2111	93194000	34.45

OSF - Audited By:

TOTAL AMOUNT $ 34.45

FOR $ 34.45 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of He

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

OFFICIAL DUTY STATION: Miami, OK

NATURE OF OFFICIAL BUSINESS: Lead Project (391)

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1998 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount	
Fairland*-Afton 9Vo Tech-Fair	11	16	16									
Fairland*-Afton-Fairland		17	16									
Fairland*-Afton-Fairland		18	16									
Bairland*-Afton-Fairland		19	16									
Fairland*-Afton-Fairland		20	16									
Miami-Picher-Miami		30	20	6								
*Travel from home closer than homebase			100	6								
TOTALS				106	TOTAL MILES @ .325						PER MILE =	34.45

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 34.45

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 4 9 1999

My Commission expires 5 27 2002 Janice Lem
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or Financial Management

Agency's Approving Officer

Title

Agency, Bd., or Div Use

APR 22 1999
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19 (Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
4100	340		930578

FOR AGENCY USE: 9799 NWOA 011743

CLAIM OF: Susan Waldron

PERSONAL IDENTIFIER(S) REDACTED S.S. No.

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____ NO XX	009925	42000	2111	93.124/000	33.15
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____	OSF - Audited By:			TOTAL AMOUNT $	33.15

FOR $ 33.15 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Hea

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 7695355
WARR DATE: 04/28/1999

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami, OK	Lead Project (391)

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 98 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount	
Miami-Vicinity	12	01		6								
Miami-Vicinity		02		6								
Miami-Big Cabin-Miami		18	70									
Miami-Picher-Miami		21	20									
TOTALS			90	12	102 TOTAL MILES @		.325		PER MILE =			33.15

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS	
RENTAL CAR:	PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC COSTS:	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	33.15

I, Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 4-9 19 99

My Commission expires 5-27-2002

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Officer

Director, Financial Management

Agency's Approving Official

Title

Agency, Bd., or Div. Use

APR 22 1999
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19 4/12/99
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		930579

FOR AGENCY USE: BT 99 NWOA 011743

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42000	2111	93194000	29.58

OSF - Audited By:

TOTAL AMOUNT $ 29.58

FOR $ 29.58 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of I

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7895336
WARR DATE: 04\28\1999
CLAIM NO: 930579

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami, OK	Lead Project (391)

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1999 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity	01	5		6							
Miami-Vicinity		6		5							
Miami-Commerce-Miami		12	8	2							
Miami-COmmerce-Miami		15	8								
Miami-Vicinity		19		8							
Miami-Vicinity		20		4							
Miami-Vicinity		21		4							
Miami-Vicinity		22		6							
Miami-Vicinity Commerce-Miami		25	20	4							
Miami-Commerce-Miami		28	8	4							
TOTALS			44	47							

91 TOTAL MILES @ .325 PER MILE = 29.58

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING	TOTAL MISC
OTHER LOCAL TRANSP.	OTHER MISC COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 29.58

I, Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 4-9, 1999

My Commission expires 5-27-2002

Janice Ann Nichols
Approving Supervisor's Signature

Janice Ann Nichols
Notary Public (or Clerk or Judge)

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act of

Financial Management

Agency's Approving Officer

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354
APR 22 1999

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	S013632	927080

FOR AGENCY USE
WARRANT # 7805057 DATE: 03/29/99

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42000	2211	000000000	373.33

CLAIM OF:
TRAVEL AGENTS INC.
731270787

9
2
7
0
8
0

FOR
$ 373.33

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
088		373.33

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 990223

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/23/99	0030195	373.33

THIS SPACE FOR AGENCY USE

400BT99 009935NW97 221110088X 373.33

J/E XREF:

VENDOR: TRAVEL AGENTS INC.
ADDRESS: 9415 NORTH MAY
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73120

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

03/23/99
Date

Agency, Bd or Div. Use

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

927080 16 ver

[illegible] PERSON: [illegible] ITINERARY/INVOICE NO. [illegible] DATE: [illegible]
[illegible] NUMBER: [illegible] [illegible] PAGE: [illegible]

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO RUBY SHERWIN 3RD FLOOR TRAVEL DIVISION
TKT O DEED BY ELVIA
PURCHASE ORDER NUMBER [illegible] 088

[illegible] SUSAN REF:

PERSONAL IDENTIFIER(S) REDACTED

[illegible] 99 [illegible]

AIR	TRANS WORLD AIRLINES FLT [illegible]	COACH	
	LV [illegible]	[illegible]	[illegible]
			[illegible]
	AR ST LOUIS INTL	[illegible]	NON STOP
	ARRIVE: MAIN TERMINAL		REF: [illegible]
	WALDRON/SUSAN [illegible]		
AIR	TRANS WORLD AIRLINES FLT [illegible]	COACH	
	LV ST LOUIS INTL	[illegible]	[illegible]
	DEPART: MAIN TERMINAL		[illegible]
	AR ATLANTA	[illegible]	NON STOP
			REF: [illegible]
	WALDRON/SUSAN [illegible]		

[illegible] 99 [illegible]

AIR	TRANS WORLD AIRLINES FLT [illegible]	COACH	
	LV ATLANTA	[illegible]	[illegible]
			[illegible]
	AR ST LOUIS INTL	[illegible]	NON STOP
	ARRIVE: MAIN TERMINAL		REF: [illegible]
	WALDRON/SUSAN [illegible]		
AIR	TRANS WORLD AIRLINES FLT [illegible]	COACH	
	LV ST LOUIS INTL	[illegible]	[illegible]
	DEPART: MAIN TERMINAL		[illegible]
	AR TULSA	[illegible]	NON STOP
			REF: [illegible]
	WALDRON/SUSAN [illegible]		

AIR TICKET	[illegible]	WALDRON/SUSAN	[illegible]
		SUB TOTAL	[illegible]
		TOTAL AMOUNT DUE	[illegible]

[illegible]

[illegible]

Disc 6.67
373.33
AB

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS

RECEIVED
FEB 11 1999
Regional Health Finance

S013632 CG E Mail for increase 13.7

OKLAHOMA STATE DEPARTMENT OF HEA

INTERSTATE TRAVEL REQUEST/AUTHORIZA

Susan Waldron - Atlanta - 298

2/24 2/26 3/1 3/3 3/9 3/9 ok to check

Control No.
Date 2/19/99 PH
Budget Code
[redacted]
731-270-787
221110088X

DIVISION: MCH (Ottawa County Health Departm 293

400BT99 009935NW97 42

TO BE CHARGED TO: ATSDR - Ottawa County - Site Specific (Fund & Account) 0 % (State) 100 % (Federal)

93 1740000 93200

APPLICANT: Susan Waldron POSITION (Title): PHCWIII

00543T

DATE OF DEPARTURE: 3/7/99

NATURE OF TRIP (School, Meeting, Convention, etc.): ~~ATSDR mandatory meeting~~

1999 ATSDR Partners in Public Health (Name) 3/8 thru 3/12/99 (Date) Atlanta, GA. (Location)

MODE OF TRAVEL (Private - Public): Air/public

Ref w/disc

ESTIMATED COST: $ 359.59 (Travel) $ 130.00 (per diem) 25.00 registration 50.00 ground trans. $ 360.00 lodging (Other) $ 924.59 (Total)

JUSTIFICATION FOR TRIP: ATSDR Cooperative Agreement Training, required per grant

~~Specifically~~ by the grant.

Refundable is $366.00. Discount is $6.41.

DURATION OF TRIP WILL INCLUDE 4 DAYS AT MEETING AND 1 DAYS ENROUTE.

TOTAL OF 5 DAYS.

APPROVED: Suzanna Dooley/pw
Service or Office Chief/Division Director

APPROVAL AND TRAVEL AUTHORIZATION

The individual named hereon is authorized to perform official travel as indicated.

J Rhoda MD
Commissioner

2-19-99
Date

OSDH Form No. 81
(Rev. 8/78)

FILENAME: OTTAWA CO. LEAD POISON PREV.

Prepared By: GDS 12-23-1999

TIME AND EFFORT
COST ACCUMULATION SCHEDULE

GRANT NAME: CDC/CONDUCT SITE-SPECIFIC ACTIVITIES
GRANT NUMBER: U50/ATU686520-01
BUDGET PERIOD: 09/29/96 TO 09/28/99
PGM CODE : 381

	== PROGCOST ==				== 244 OTHER ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	2 69	3 43	-	19 74	-	-	-	-
NOVEMBER	17.50	33.13	-	155 18	-	-	-	-
DECEMBER	23 92	44 75	-	179 66	-	-	-	-
JANUARY 99	36 23	36 09	-	192 94	-	-	-	-
FEBRUARY	25 87	29 17	-	154 37	-	-	-	-
MARCH	40 96	42 65	-	212 25	-	-	-	-
APRIL	32 19	48 20	-	216 33	-	-	-	-
MAY	29 01	45 17	-	303 87	-	-	-	-
JUNE	39 18	39 55	-	366 62	-	-	-	-
JULY	20.41	49 95	-	116 29	-	-	-	-
AUGUST	32.43	51 31	-	269 15	-	-	-	-
SEPTEMBER	31 66	39 82	-	460 50	-	-	-	-
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	334 07	463 72	-	2,666 90	-	-	-	-

	== 301 OTHER ==				== TOTAL ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	0 52	0 68	-	3 79	3 21	4 09	-	23 53
NOVEMBER	2 48	4 85	-	21.79	19 98	37.76	-	176.97
DECEMBER	3 00	5 82	-	22 57	26 92	50 57	-	202 23
JANUARY 99	5 46	5 17	-	27 64	43 71	41 26	-	220 58
FEBRUARY	3 43	3 86	-	20 48	29 30	33 03	-	174 85
MARCH	4 56	4 75	-	23 63	45 54	47.40	-	235 88
APRIL	3 63	5 73	-	25.74	36 02	53 93	-	242 07
MAY	3.14	4 89	-	32 93	32 15	50 06	-	336 80
JUNE	4 55	4 59	-	42.56	43 73	44 14	-	409 18
JULY	2 14	5 24	-	12 19	22 55	55 19	-	128 48
AUGUST	3 19	5 05	-	28 46	35 62	56 36	-	317 61
SEPTEMBER	3 53	4 44	-	53 84	35 19	44 26	-	534.14
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	38 63	54 85	-	315 40	373 80	517 87	-	3,009 30

	TOTAL NON-PAYROLL
JULY 98	-
AUGUST	-
SEPTEMBER	-
OCTOBER	30 83
NOVEMBER	234.71
DECEMBER	279 52
JANUARY 99	305 55
FEBRUARY	237.18
MARCH	326 82
APRIL	332 02
MAY	418 01
JUNE	497.05
JULY	206 72
AUGUST	408 59
SEPTEMBER	613 59
OCTOBER	-
NOVEMBER	-
DECEMBER	-
TOTAL	3,694.07

EQUIPMENT

9/29/1998 to 9/28/1999

Claims	6,250.90
PROGCOST - Equipment	-
Total Equipment	$ 6,250.90

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T022447	010496

FOR AGENCY USE: WARRANT # 7324859 DATE: 10/14/1999

ACCOUNT	SUB-ACTIVITY	OBJECT	CEDA		AMOUNT
000035	42000	3111	932000000		11.87
000035	42000	3613	932000000		85.00
000035	42000	3721	932000000		748.00
000035	42000	4116	932000000	Equip	3,600.00

CLAIM OF:
ESA, INC
042447948

FOR
$ 4,444.87

AGAINST
Agency, Board, Comm., Dept.: Okla. State Dept. of Health

0 1 0 4 9 6

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	4,444.87
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 19990913

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
09/13/1999	563868	4,444.87

THIS SPACE FOR AGENCY USE

400BT90	000035NW97	3111AAAAAX	11.87
400BT90	000035NW97	3613AAAAAX	85.00
400BT90	000035NW97	3721AAAAAX	748.00
400BT90	000035NW97	4116AAAAAX	3600.00

J/E XREF:

VENDOR: ESA, INC
ADDRESS: 22 ALPHA RD
ADDRESS:
CITY/ST/ZIP: CHELMSFORD MA 018244171

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer _____ 10/11/1999

Title _____ Date

Agency, Bd or Div. Use

0104960

'04 2447948

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

	Date	Number
INVOICE	09/13/99	563868
Sales Order	09/13/99	211729

Ship Via BEST WAY
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
1000 NORTHEAST 10TH STREET
ATTN; SHIPPING & RECEIVING
OKLAHOMA CITY, OK 73117-1299

GRACE BROWN 405-271-4042 LC

T022447

Payment Terms NET 30 | Sales Rep # 36 | Cust PO 211729

Line	Qty	Part Number	Description	Unit Price	Value
1	2	70-3449	LEADCARE ANALYZER KIT	1800.0000	3600.00
			Ser#: 807039 809039		
2	2	70-2233	LEADCARE BLOOD LEAD TEST KIT	288.0000	576.00
3	2	70-3440	LEADCARE CONTROL KIT	35.0000	70.00
4	2	40-0125	PIPET TIPS CLEAR (NATURAL)	12.0000	24.00
5	2	70-3662	CAPILLARIES BLOOD LEAD COLLECTION	30.0000	60.00
6	1	70-3550	CABLE LEADCARE INTERFACE RS232	85.0000	85.00
7	2	70-3663	PLUNGERS BLOOD LEAD COLLECTION	9.0000	18.00

400BT90
000035NW97
42000
3111 = 11.87
3613 = 85.00
3721 = 748.00
4116 = 3600.00

10-7-99

Sale Amount	4433.00
Misc Amount	.00
Sales Tax	.00
Freight	11.87
TOTAL	4444.87

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

0424417948

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Sales Order
PICK LIST
Order

Date / Number
09/13/99 211729
09/13/99

Ship Via BEST WAY
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
1000 NORTHEAST 10TH STREET
ATTN; SHIPPING & RECEIVING
OKLAHOMA CITY, OK 73117-1299

GRACE BROWN 405-271-4042 LC

Payment Terms: NET 30
Sales Rep # 36
Cust PO: 211729

FO 9038
FO 7039

Line	Qty.	U/M	Part Number	Description	Scheduled Ship Date	Qty. Shipped
1	2	EA	70-3449	LEADCARE ANALYZER KIT	09/13/99	2
			STOCKROOM: MAIN	LOCATION: SHIP		
2	2	EA	70-2233	LEADCARE BLOOD LEAD TEST KIT AF5	09/13/99	2
			STOCKROOM: MAIN	LOCATION: SHIP		
3	2	EA	70-3440	LEADCARE CONTROL KIT	09/13/99	2
			STOCKROOM: MAIN	LOCATION: FRIG BC9907-05		
4	2	PK	40-0125	PIPET TIPS CLEAR (NATURAL)	09/13/99	2
			STOCKROOM: MAIN	LOCATION: FLOOR		
5	2	EA	70-3662	CAPILLARIES BLOOD LEAD COLLECTION 04.02.99	09/13/99	2
			STOCKROOM: MAIN	LOCATION: BULK10		
6	1	EA	70-3550	CABLE LEADCARE INTERFACE RS232	09/13/99	1
			STOCKROOM: MAIN	LOCATION: D6		
7	2	EA	70-3663	PLUNGERS BLOOD LEAD COLLECTION	09/13/99	2
			STOCKROOM: MAIN	LOCATION: BULK10		

RECEIVED
SEP 17 1999
SHIPPING & RECEIVING

Linda Wilson

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	S062799	927976

FOR AGENCY USE
WARRANT # 7838964 DATE: 04/09/99

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	88042	4111	939190000	245.00

CLAIM OF:
ARMSTEC
234250842

9
2
7
9
7
6

FOR
$ 245.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	245.00
001		OSF-AUDITED BY	

Date: _____
Claimant: _____

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 990312

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/12/99	9900168	245.00

THIS SPACE FOR AGENCY USE

400BT99 009935NW97 4111AAAAAX 245.00

J/E XREF:

VENDOR: ARMSTEC
ADDRESS: 5123 EAST 108TH STREET
ADDRESS:
CITY/ST/ZIP: TULSA OK 74137

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise.Contractor estimates must be approved by the architect or engineer in charge of the project.Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/29/99

Title Date

Agency, Bd or Div. Use

INVOICE

427976
B

ARMSTEC

5123 East 108th. Street Tulsa OK 74137-7242
Ph: 918-298-4060, Fax: 918-298-4062

Date	Invoice
3/12/99	9900168

Bill To :

34000
Oklahoma State Department of Health
Accounts Payable
1000 North East 10th. Street
Oklahoma City OK 73117-1299

Ship To :

34001
Oklahoma State Department of Health
Shipping & Receiving
1000 North East 10th. Street
Oklahoma City OK 73117-1299

Delivery	PO Number	PO Date	Terms
UPS Ground	S062799	3/10/99	Net 10

1	Iomega Jaz 2GB Media 3-Pack. PN: 10597	$245.00	$245.00

Pay this amount

Shipping :	$0.00	**Sales Tax :**	$0.00
Discount :	$0.00	**Total :**	$245.00

Terms and Conditions on reverse side of this page

PACKING SLIP

Ship From

ARMSTEC
5123 EAST 108TH STREET
TULSA OK 74137

Ship To

S062668/S063163
DEPT. OF HEALTH
SHIPPING AND RECEIVING
1000 NE 10TH ST.
OKLAHOMA CITY OK 73117

Ord Date	Ship Via	Customer PO	Reference #
03/13/1999	UPS GROUND	S063165/S062799	S063165/S062799

Line Nbr	PO Line	Qty Order	Qty Ship	SKU #	Description	Price	Extended/ Retail
001		1	1	729774	JAZ 2GB PC CARTRIDGE 3PK PREFORMATTED DISK ACCS CPU: IBM-PC UPC: 0742709105975 MFG PART: 10597 CARTON #s: 00001		
002		1	0	729782	PROMO JAZ JET PCI FOR MAC ACCS CPU: MAC UPC: 0742709103001 MFG PART: 10300		
003		13	13	383376	SURGE SUPER 7 7 OUTLET 7'-CORD DIAGNOSTICS LIFE ULT INS 5 YR WAR ACCS CPU: UNIVER UPC: 0037332010599 MFG PART: SUPER 7 CARTON #s: 00001, 00003		
005		1	1	239649	16X/4X/4X REWRITABLE EIDE DRIV CPU: IBM-PC UPC: 0086792275178 MFG PART: CRW4416E CARTON #s: 00002		

RECEIVED
MAR 17 1999
SHIPPING & RECEIVING

C Lodes

Carton Numbers Shipped: 00001, 00003, 00002

Total Quantity Shipped: 15
Total Cartons Shipped: 3

Trk Nbrs: 1ZE370580345707551, 1ZE370580345713428, 1ZE370580345714500

TS ARE REGULATED BY THE U.S. DEPT. OF COMMERCE AND ARE SUBJECT TO EXPORT CONTROL REGULATI

CARDI @ 3373 Dest: GDPP SID: 3015 20-9424

INVOICE

ARMSTEC
5123 East 108th. Street Tulsa OK 74137-7242
Ph: 918-298-4060, Fax: 918-298-4062

Date	Invoice
3/12/99	9900168

Bill To :

34000
Oklahoma State Department of Health
Accounts Payable
1000 North East 10th. Street
Oklahoma City OK 73117-1299

Ship To :

34001
Oklahoma State Department of Health
Shipping & Receiving
1000 North East 10th. Street
Oklahoma City OK 73117-1299

Delivery	PO Number	PO Date	Terms
UPS Ground	S062799	3/10/99	Net 10

1	Iomega Jaz 2GB Media 3-Pack. PN: 10597	$245.00	$245.00

Pay this amount

Shipping :	$0.00	**Sales Tax :**	$0.00
Discount :	$0.00	**Total :**	$245.00

Terms and Conditions on reverse side of this page

INVOICE

ARMSTEC
5123 East 108th. Street Tulsa OK 74137-7242
Ph: 918-298-4060, Fax: 918-298-4062

Date	Invoice
3/12/99	9900168

Bill To :
34000
Oklahoma State Department of Health
Accounts Payable
1000 North East 10th. Street
Oklahoma City OK 73117-1299

Ship To :
34001
Oklahoma State Department of Health
Shipping & Receiving
1000 North East 10th. Street
Oklahoma City OK 73117-1299

Delivery	PO Number	PO Date	Terms
UPS Ground	S062799	3/10/99	Net 10

1	Iomega Jaz 2GB Media 3-Pack. PN: 10597	$245.00	$245.00

Pay this amount

Shipping :	$0.00	**Sales Tax :**	$0.00
Discount :	$0.00	**Total :**	$245.00

Terms and Conditions on reverse side of this page

RECEIVING REPORT

Received at OKLAHOMA STATE HEALTH DEPARTMENT
1000 N.E. 10th Street
Oklahoma City, Oklahoma 73152

Received from (Vendor) ARMS TECH

Delivered by

(Vendor, Mail or Express of Carrier)

Order No.	Partial	Complete	Date Received
S062799			3/23/99

Quantity	Unit	Description
1	ea	3 PACK 2GB CARTRIGES

Pam Perry

RECEIVED
MAR 23 1999
SHIPPING & RECEIVING

I certify that the items described above were received and inspected by me, that the quantities were as stated, and the condition was satisfactory except as otherwise stated.

ODH #30 (3/97)

PAM @8333

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	S063681	929138

FOR AGENCY USE
WARRANT # 7856823 DATE: 04/15/99

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	88042	4112	000000000	347.90

CLAIM OF:
TECH PARTNERS DBA INACOM INFO
710724781

FOR
$ 347.90

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		347.90

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 990325

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/29/99	100630	347.90

THIS SPACE FOR AGENCY USE

400BT99 009935NW97 4112AAAAAX 347.90

J/E XREF:

VENDOR: TECH PARTNERS DBA INACOM INFO
ADDRESS: PO BOX 537
ADDRESS:
CITY/ST/ZIP: LITTLE ROCK AR 72201

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

04/08/99

Title Date

Agency, Bd or Div. Use

929138 DEL

INVOICE

inacom
Information Systems ™

2201 BROOKWOOD, SUITE 121
LITTLE ROCK, AR 72202
(501) 663-8585 FAX (501) 663-9182

710724781

BILL TO:

OKLAHOMA STATE DEPT OF HEALTH
[illegible]
[illegible] ACCOUNTS PAYABLE
OKLAHOMA CITY OK 73117-1299

SHIP TO:

[illegible]
[illegible]
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

[redacted]/29/99 [redacted]

UNITS					
		CUST PO DT: 31299			
1	EA	3047 LOC 012		347.900	347.90
		JAZ 2GB EXT SCSI FOR MAC & PC			
		WITH CD TOOLS W/O CARTRIDGE			
		Subtotal			347.90
		Total Due On 04/18/99			347.90

[redacted]

4412 A-X

RECEIVED
1999 APR -1 A 9:29
[illegible] MANAGEMENT

REMIT TO: P.O. BOX 537 Little Rock AR 72201
THANK YOU FOR YOUR BUSINESS!

PAMELA M. WARREN
Secretary of Administration
Director

FRANK KEATING
Governor

STATE OF OKLAHOMA
DEPARTMENT OF CENTRAL SERVICES

March 21, 1999

Rusty Wood, Client Service Representative
Inacom Information Systems dba Technology Partners
1913 Wet Tacoma, Suite A
Broken Arrow, OK 74012

Re: SW92040 Substitutions

Dear Mr. Wood:

I have received and approved your request for substitution of the following:

0206-44-10-200 Toshiba Internal CD-ROM

From:	Manu XM6201B-S	To:	Manu XM6401B-S
	Vendor # 889665		Vendor # 88974
	32X CD Rom		40X CD Rom

0206-46-50-400 Iomega Jazz Drive 2GB w/2GB Jazz tools

From:	Manu 10508	To:	Manu 13047
	Vendor # 366388		Vendor # 366632

This change is effective 3-19-99, with no change in the price. The contract will be corrected in the State of Oklahoma Purchasing Computer System. A hard copy will not be sent out to all the agencies. This correction will also be annotated on the new issue effective 4-1-99.

I would suggest that when these products are ordered that a copy of the substitution approval letter accompany either the invoice and/or the product.

If you have any questions, please do not hesitate to contact me at (405) 521-2131 or via email at cperryma@dcs.state.ok.us

Sincerely,

Cindy K Perry

Cindy Perryman, Contracting Officer
Central Purchasing

cc: SW file

inacom
Information Systems

ORDER PACKING LIST

SHIP TO	SHIPPED FROM		DATE SHIPPED	CUSTOMER PO REF	LOAD #
OK STATE DEPT OF HEALTH ATTN: SHIPPING&RECEIVING 1000 N.E. 10TH STREET OKLAHOMA CIT, OK 73117	TECHNOLOGY PARTNERS INC 5100 LIBERTY WAY FORT WORTH, TX 76178		03/24/99	S063681	798198
					# OF CARTONS
					1
				ORDER TAKEN	
				WORLD WIDE WEB	

CUSTOMER CONTACT: ANGIE MCKEE

QTY SHIPPED	UM	ORDER LINE	ITEM #	VENDOR ITEM #	UPC#	ITEM DESCRIPTION	
1	EA	1	366632	13047	742709130472	JAZ 2GB EXT SCSI DRIVE	W/2GB JAZ TOOLS CD

CONTAINER ID: 1Z7493280342618235

TOTAL NUMBER OF ITEMS: 1
SHIP VIA: UPS GROUND
PACKER: WILLIE SADLER

CONTAINER ID	WEIGHT	NUMBER OF PIECES
1Z7493280342618235	5.40	1

inacom

RECEIVED
MAR 25 1999
SHIPPING & RECEIVING

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	S062798	928225

FOR AGENCY USE: WARRANT # 7826541 DATE: 04/06/99

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	88042	4111	000000000	2,058.00

CLAIM OF:
GATEWAY 2000 MAJOR ACCTS, IN
460432792

FOR
$ 2,058.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	2,058.00
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/17/99	40654838	2,058.00

THIS SPACE FOR AGENCY USE

400BT99 009935NW97 4111AAAAAX 2058.00

J/E XREF:

VENDOR: GATEWAY BUSINESS
ADDRESS: PO BOX 14427
ADDRESS:
CITY/ST/ZIP: DES MOINES IA 503063427

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Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/31/99

Title Date

Agency, Bd or Div. Use

Gateway BUSINESS™

610 Gateway Drive
North Sioux City, South Dakota 57049
Telephone: 800-779-2000
Fax: 605-232-2718

INVOICE

Remittance Address
Gateway
P.O. Box 14427
Des Moines, IA 50306-3427

Invoice Date	Invoice #	Client P.O.	Client I.D.	Sales Representative
03/17/99	40654838	*S062798	15081221	PIH75

Payment Terms	Ship Via	Gateway Order #	Order Date
SEE BELOW	UPS Ground	20439894	03/16/99

SOLD TO

*S062798
OK ST DEPT OF HEALTH
ACCOUNTS PAYABLE
1000 NE 10TH ST
REF#S062798
OKLAHOMA CITY OK 73117-1299

SHIP TO

OK ST DEPT OF HEALTH
SHIP/REC
1000 NE 10TH ST
REF#S062798
OKLAHOMA CITY OK 73117

FOB Destination

MAJOR ACCOUNT INVOICE

Quantity	Item # / Description		System Serial #	Unit Price	Amount
1	1002387 Enterprise E-4200 450 PC Serial Numbers for item 1002387	Shipped	0013252809	1768.00	1768.00
1	NOSOFTWARE No Application Software	Shipped		.00	.00
1	1507002 Years 2 & 3 of Onsite Service	Shipped		.00	.00
1	7000957 EV700 17" Monitor with 15.9" Viewable	Shipped		290.00	290.00

Sales Tax .00

These commodities are licensed by the United States.
Diversion contrary to U.S. law is Prohibited.

REF#S062798

Payment Terms Major Accounts Net 30 Pur

460 432 792
400BT99
009935NW97
88042
4111

Purchase Sub-Total	Sales Tax	Freight & Handling	INVOICE TOTAL
2058.00	.00	.00	2058.00

Tax Rt

Page # 1

Please return this portion with your payment. Disregard this notice if payment has been made.

Please remit payment for the full amount of this invoice within 30 days. Balances after 30 days will be considered delinquent. We appreciate your business.

REMIT TO:
Gateway BUSINESS
P.O. Box 14427
Des Moines, IA 50306-3427
Telephone: 800-779-2000
Fax: 605-232-2718

Client ID	Invoice Date	Invoice #	Invoice Total
15081221	03/17/99	40654838	2058.00

Gateway

610 Gateway Drive
North Sioux City, South Dakota 57049

If you have any questions please contact our
Customer Service Department at 800-846-2000
Fax 605-232-2023
7 a.m. to 10 p.m. Monday through Friday (Central Time)
9 a.m. to 4 p.m. Saturday (Central Time)

PACKING SLIP

Client P.O.	Order Date	Ship Date	Client I.D.	Order #	Sales Representative
*S062798	03/16/99	03/17/99	15081221	20439894	PIH75

GATEWAY USE ONLY

Client Contact	# of Boxes	Terms	Ship Via
		$	UPS Ground FOB Destination

SHIP TO
405 271-4043
OK ST DEPT OF HEALTH
SHIP/REC
1000 NE 10TH ST
REF#S062798
OKLAHOMA CITY OK 73117

SOLD TO
OK ST DEPT OF HEALTH
ACCOUNTS PAYABLE
1000 NE 10TH ST
REF#S062798
OKLAHOMA CITY OK 73117-1299

1.000	1	1	1002387 Enterprise E-4200 450 PC	0013252809 ODH# 990089
1.010	1	1	Pentium III AirDuct	
1.020	1	1	Mid-Tower Case	
1.030	1	1	128MB Memory Module	
1.040	1	1	Motherboard with Intel 450MHz Pentium III Processor	
1.050	1	1	3.5" 1.44 MB Floppy Diskette Drive	
1.060	1	1	13x Min. /32x Max. IDE CDROM	
1.070	1	1	Shroud for Intrusion Switch	
1.080	1	1	US Robotics 56K WinModem with Speakerphone	
1.090	1	1	ATI Rage Pro Turbo 8MB AGP Graphics Accelerator	
1.100	1	1	Digital PCI Sound Card	
1.110	1	1	3COM PCI 10/100 Twisted Pair Adapter	
1.120	1	1	Bezel Label	
1.130	1	1	Microsoft Intellimouse	
1.140	1	1	104 Key Keyboard	
1.150	1	1	Microsoft Windows 98	
1.160	1	1	Fat 32 for Windows 95 or 98	
1.170	1	1	MegaPhone SW and Info. Highway	
1.180	1	1	Boot System CD	
1.190	1	1	LANdesk Client Manager Software	
1.200	1	1	Manuals	
1.210	1	1	Gateway Gold Service and Support	
1.220	1	1	GCS100 Speakers by Altec Lansing	
1.230	1	1	8.4GB 5400RPM Ultra ATA Hard Drive	
2.000	1	1	NOSOFTWARE No Application Software	
3.000	1	1	1507002 Years 2 & 3 of Onsite Service	
6.000	1	1	7000957 EV700 17" Monitor with 15.9" Viewable	

Pam Peng

S/98 #3 LASER PACK SLIP

CONTINUED

OTHER

9/29/1998 to 9/28/1999

Claims	1,729.87
PROGCOST - Other	3,002.30
Worker's Comp.	326.90
Total Other	$ 5,059.07

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T022447	010496

FOR AGENCY USE
WARRANT # 7324859 DATE: 10/14/1999

CLAIM OF:
ESA, INC
042447948

0
1
0
4
9
6

FOR
$ 4,444.87

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ACCOUNT	SUB ACTIVITY	OBJECT	CEDA	AMOUNT
000035	42000	3111	932000000	11.87
000035	42000	3613	932000000	85.00
000035	42000	3721	932000000	748.00
000035	42000	4116	932000000	3,600.00

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	4,444.87
001		OSF AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 19990913

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
09/13/1999	563868	4,444.87

THIS SPACE FOR AGENCY USE

400BT90	000035NW97	3111AAAAAX	11.87
400BT90	000035NW97	3613AAAAAX	85.00
400BT90	000035NW97	3721AAAAAX	748.00
400BT90	000035NW97	4116AAAAAX	3600.00

J/E XREF:

VENDOR: ESA, INC
ADDRESS: 22 ALPHA RD
ADDRESS:
CITY/ST/ZIP: CHELMSFORD MA 018244171

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 10/11/1999

Title Date

Agency, Bd or Div. Use

0104960

042447948

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

	Date	Number
INVOICE	09/13/99	563868
Sales Order	09/13/99	211729

Ship Via BEST WAY
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
1000 NORTHEAST 10TH STREET
ATTN: SHIPPING & RECEIVING
OKLAHOMA CITY, OK 73117-1299

GRACE BROWN 405-271-4042 LC

T022447

Payment Terms NET 30 | Sales Rep # 36 | Cust PO 211729

Line	Qty	Part Number	Description	Unit Price	Value
1	2	70-3449 ✓	LEADCARE ANALYZER KIT	1800.0000	3600.00
		Ser#:	807039 809039		
2	2	70-2233 ✓	LEADCARE BLOOD LEAD TEST KIT	288.0000	576.00
3	2	70-3440 ✓	LEADCARE CONTROL KIT	35.0000	70.00
4	2	40-0125 ✓	PIPET TIPS CLEAR (NATURAL)	12.0000	24.00
5	2	70-3662 ✓	CAPILLARIES BLOOD LEAD COLLECTION	30.0000	60.00
6	1	70-3550 ✓	CABLE LEADCARE INTERFACE RS232	85.0000	85.00
7	2	70-3663 ✓	PLUNGERS BLOOD LEAD COLLECTION	9.0000	18.00

400BT90
000035NW97
42000
3111 = 11.87
3613 = 85.00
3721 = 748.00
4116 = 3600.00

10-7-99
ol

Sale Amount	4433.00
Misc Amount	.00
Sales Tax	.00
Freight	11.87
TOTAL	4444.87

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

0424447948

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Sales Order PICK LIST
Order

Date: 09/13/99 09/13/99
Number: 211729

Ship Via BEST WAY
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
1000 NORTHEAST 10TH STREET
ATTN; SHIPPING & RECEIVING
OKLAHOMA CITY, OK 73117-1299

GRACE BROWN 405-271-4042 LC

Payment Terms: NET 30
Sales Rep # 36
Cust PO: 211729

Line	Qty.	U/M	Part Number	Description	Scheduled Ship Date	Qty. Shipped
1	2	EA	70-3449	LEADCARE ANALYZER KIT	09/13/99	2
			STOCKROOM: MAIN	LOCATION: SHIP		
2	2	EA	70-2233			
			LEADCARE BLOOD LEAD TEST KIT AF5		09/13/99	2
			STOCKROOM: MAIN	LOCATION: SHIP		
3	2	EA	70-3440	LEADCARE CONTROL KIT	09/13/99	2
			STOCKROOM: MAIN	LOCATION: FRIG		
4	2	PK	40-0125	BC9907-05		
			PIPET TIPS CLEAR (NATURAL)		09/13/99	2
			STOCKROOM: MAIN	LOCATION: FLOOR		
5	2	EA	70-3662			
			CAPILLARIES BLOOD LEAD COLLECTION 042.99		09/13/99	2
			STOCKROOM: MAIN	LOCATION: BULK10		
6	1	EA	70-3550			
			CABLE LEADCARE INTERFACE RS232		09/13/99	1
			STOCKROOM: MAIN	LOCATION: D6		
7	2	EA	70-3663			
			PLUNGERS BLOOD LEAD COLLECTION		09/13/99	2
			STOCKROOM: MAIN	LOCATION: BULK10		

80 9039
80 7039

RECEIVED
SEP 17 1999
SHIPPING & RECEIVING

Linda Wilson

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	S064975	928842

FOR AGENCY USE
WARRANT # 7856818 DATE: 04/15/99

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42000	3142	000000000	195.00

CLAIM OF:
OUHSC DEPT OF OCCU & ENV
736017987

9
2
8
8
4
2

FOR
$ 195.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		195.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 990224

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/15/99	02	195.00

THIS SPACE FOR AGENCY USE

400BT99 009935NW97 3142AAAAAX 195.00

J/E XREF:

VENDOR: OUHSC DEPT OF OCCU & ENV
ADDRESS: COLLEGE OF PUBLIC HEALTH
ADDRESS: PO BOX 26901 ROOM 413
CITY/ST/ZIP: OKLAHOMA CITY OK 73190

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

_____
Agency's Approving Officer

04/06/99

Title Date

Agency, Bd or Div. Use

928842

The University of Oklahoma

Health Sciences Center

DEPARTMENT OF OCCUPATIONAL AND ENVIRONMENTAL HEALTH

5064975 009.935WW
X 400BT 99
42000 3142 A-X
Sgf 3/30/99
INVOICE DATE

INVOICE

BILL TO: Oklahoma State Department of Health
ATTN: Account Payable
1000 Northeast 10th Street, Room 903
Oklahoma City, Oklahoma 73117-1212

Invoice Date: March 15, 1999
Invoice No.: 02

P.O. Number: Not Available

Item No.	Quantity	Unit	Description of Materials	Unit Cost	Total
1	1	Ea	Registration Fee for Ms. Susan A. Waldron to attend the LBP Risk Assessor Refresher Seminar, February 24, 1999 (see attachment).	$ 195.00	$ 195.00

REMIT PAYMENT TO: University of Oklahoma Health Sciences Center
Institute for Environmental Management
College of Public Health
Post Office Box 26901, Room 413
Oklahoma City, Oklahoma 73190

The undersigned hereby certifies that all payments requested are for appropriate purposes and in accordance with the agreement.

Mark R Cox

Mark R. Cox, Ph.D., Interim Director
Institute for Environmental Management

Invoice Prepared by Carolyn J. Scott
(405) 271-2070

College of Public Health • Post Office Box 26901 • 801 Northeast 13th, Room 413
Oklahoma City, Oklahoma 73190 • (405) 271-2070 • FAX (405) 271-1971

OTTAWA COUNTY HEALTH DEPARTMENT
OTTAWA

1930 ELM NORTHEAST
MIAMI, OKLAHOMA 74354
PHONE: 918-540-2481

FAX TRANSMISSION

Fax Number: 918-540-2486

Date: 2/10/99 Time: 8:45a.m.

To: Dr. Mark Cox

Organization: OUHSC Institute for Environmental Management

Phone: (405) 271-2070 FAX No: (405) 271-1971

THIS TRANSMISSION CONSISTS OF 2 PAGES, INCLUDING THIS PAGE. IF YOU DO NOT RECEIVE THE ENTIRE TRANSMISSION PLEASE CONTACT 918-540-2481

Ask for: Susan Waldron

MESSAGE: A purchase order will be made available from Okla. State Dept of Health for payment. Ken Cadaret 6617 @ OSDH will send the p.o. information to yo[redacted] If more information is needed, please let [redacted] Thanks!

The information contained in this facsimile message is legally privileged and confident[redacted] only for the use of the individual or entity named above. If the reader of this message is [redacted] you are hereby notified that any dissemination, distribution, or copy of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone and return the original to us at the address via the US Postal Service.

Signed: _____

Ottawa County Health Department
1930 N. Elm Miami, OK 74354

The University of Oklahoma

Health Sciences Center

INSTITUTE FOR ENVIRONMENTAL MANAGEMENT

REGISTRATION FORM

NAME Susan (First) A. (Middle) Waldron (Last)

SOCIAL SECURITY NUMBER PERSONAL IDENTIFIER(S) REDACTED

HOME ADDRESS PERSONAL IDENTIFIER(S) REDACTED

CITY PERSONAL IDENTIFIER(S) REDACTED STATE ZIP PERSONAL IDENTIFIER(S) REDACTED

HOME PHONE NUMBER PERSONAL IDENTIFIER(S) REDACTED

HOME FAX NUMBER ( ) ____-____ HOME E-MAIL ____

EMPLOYER Ottawa County Health Department

BUSINESS ADDRESS 1930 N. Elm

CITY Miami STATE OK ZIP 74354-____

BUSINESS TELEPHONE NUMBER (918) 540 - 2481 EXT. 231

PAGER ( ) ____-____ MOBILE ( ) ____-____

BUSINESS FAX NUMBER (918) 540 - 2486 BUSINESS E-MAIL susanaw@health.state.ok.us

Check course registering for:

___ LBP Inspector Refresher
February 1, 1999 $195.00 per person

___ LBP Risk Assessor Refresher
February 2, 1999 $195.00 per person

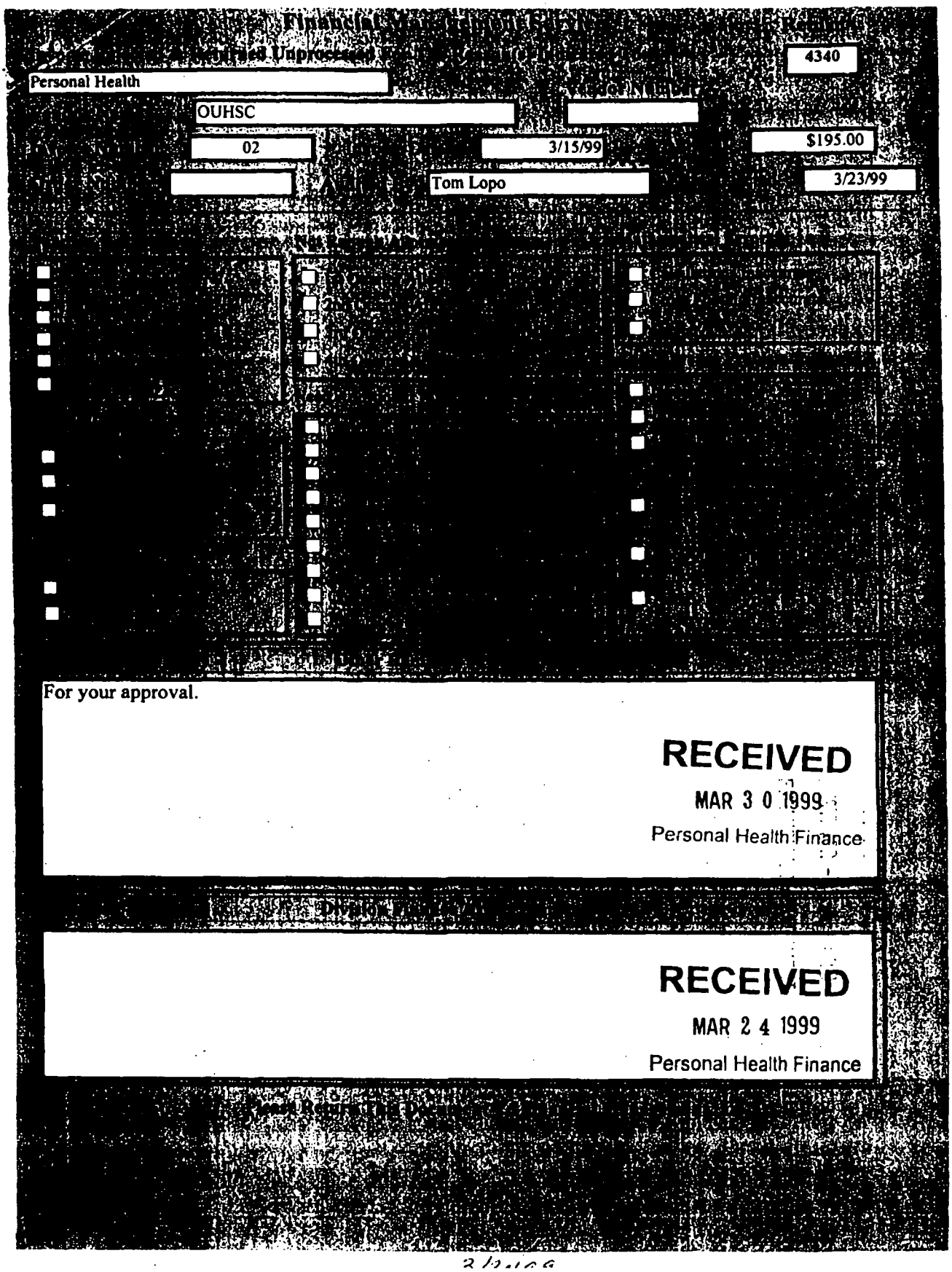
___ LBP Risk Assessor Refresher
March 1, 1999 $195.00 per person

___ LBP Abatement Supervisor Refresher
February 3, 1999 $195.00 per person

___ LBP Abatement Worker Refresher
February 4, 1999 $195.00 per person

X LBP Risk Assessor Refresher
Feb. 24, 1999
(Commerce, OK)

[illegible] Oklahoma 73190 • (405) 271-2070 FAX: (405) 271-1971


Personal Health
OUHSC
02
3/15/99
Tom Lopo
4340
$195.00
3/23/99
For your approval.
RECEIVED
MAR 3 0 1999
Personal Health Finance
RECEIVED
MAR 2 4 1999
Personal Health Finance

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	S039793	916748

FOR AGENCY USE: WARRANT # 7516642 DATE: 12/17/98

ACCOUNT	SUB-ACTIVITY	OBJECT	CEDA	AMOUNT
009935	42000	3911	931740000	295.00

CLAIM OF:
OUHSC COLLEGE OF PUBLIC HEALT
736017987

FOR
$ 295.00

AGAINST
Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR NO.)

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		295.00

OSF-AUDITED BY

Receipt of Goods or Services Date (OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 981120

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/01/98	01	295.00

THIS SPACE FOR AGENCY USE

400BT99 009935NW0A 3911AAAAAX 295.00

J/E XREF: doef 99174

VENDOR: OUHSC COLLEGE OF PUBLIC HEALTH
ADDRESS: SCB ROOM 116
ADDRESS: P O BOX 26901
CITY/ST/ZIP: OKLA CITY OK 73190

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

12/14/98

Title Date

Agency, Bd or Div. Use

p11

The University of Oklahoma

Health Sciences Center

DEPARTMENT OF OCCUPATIONAL AND ENVIRONMENTAL HEALTH

INVOICE - Revised

BILL TO: Oklahoma State Department of Health
ATTN: Account Payable
1000 Northeast 10th Street, Room 903
Oklahoma City, Oklahoma 73117-1212

Invoice Date: December 1, 1998
Invoice No.: 01

P.O. Number: S039793

Item No.	Quantity	Unit	Description of Materials	Unit Cost	Total
1	1	Ea	Registration Fee for Ms. Susan A. Waldron to attend the Lead-Based Paint Risk Assessor Seminar, November 19-20, 1998. Jaince M. Linn did not attend.	$ 295.00	$ 295.00

REMIT PAYMENT TO: University of Oklahoma Health Sciences Center
Institute for Environmental Management
College of Public Health
Post Office Box 26901, Room 413
Oklahoma City, Oklahoma 73190

The undersigned hereby certifies that all payments requested are for appropriate purposes and in accordance with the agreement.

RECEIVED
DEC 07 1998

Mark R. Cox, Ph.D., Interim Director
Institute for Environmental Management

$ 295.00

S039793 PO# or CT#	009935NWDA Account Numbe
/ / Complete-Partial	4006T99 Fund Number
42000 Sub-Activity	3911A X Object Code
/ / Math Entered	Claim Number
T.HICKS INV Funded By	12/8/98 Date

Invoice Prepared by Carolyn J. Scott
(405) 271-2070

Financial Management Service

Return#: 2625

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To:

Personal Health

Vendor Name: OUHSC

Vendor Number:

Invoice Number 01 **Invoice Date:** 12/1/98 **Amount** $295.00

Order Number S039793 **Audited By** Tom Lopo **Date Rejected:** 12/7/98

Funding

- [x] Funding Not Indicated
- [ ] Does Not Match Encumbrance
- [ ] Invalid Fund
- [ ] Invalid Account
- [ ] Invalid Sub-Activity
- [ ] Invalid Object Code

Signature

- [ ] Vendor Signature
- [ ] Supervisor Signature
- [ ] Funding Block Signature

Verify The Following:

- [ ] Verify Vendor FEI #
- [ ] Verify Order #

Not Enough Allotment:

- [ ] 1st Quarter Allotment Insufficient
- [ ] 2nd Quarter Allotment Insufficient
- [ ] 3rd Quarter Allotment Insufficient
- [ ] 4th Quarter Allotment Insufficient

Need Additional Information:

- [ ] Certified Invoice Copy
- [ ] Proof of Delivery
- [ ] Notary Seal Missing
- [ ] Notary Signature Missing
- [ ] Notary County or State Incomplete
- [ ] Notary Expired (Not Valid)
- [ ] Changes Need Justification
- [ ] Changes Need Authorizing Initials
- [ ] Item Not Found

Mathematical Errors:

- [ ] Calculations Inaccurate
- [ ] Cross Footing Inaccurate
- [ ] Price Discrepancy

Encumbrance Problem:

- [ ] Invoice Exceeds Contract
- [ ] Invoice Exceeds Encumbrance
- [ ] Order Finalled

Required Dates:

- [ ] Invoice Date Prior to Date of Service
- [ ] Notary Date Prior to Date of Invoice
- [ ] Notary Date Prior to Date of Service

Other Remarks or Comments:

Division Finance Area Comments

Lead Based Paint
NW

OK TRH 12/8/98 TRH

Please Return This Document To Financial Management

RECEIVED

DEC 07 1998

Personal Health Finance

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	S039793	916749

FOR AGENCY USE
WARRANT # 7516643 DATE: 12/17/98

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
009935	42000	3911	931740000	395.00

CLAIM OF:
OUHSC COLLEGE OF PUBLIC HEALT
736017987 9
1
6
7
4
9

FOR
$ 395.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARREN LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	395.00
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 981118

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/01/98	02	395.00

THIS SPACE FOR AGENCY USE

400BT99 009935NW0A 3911AAAAAX 395.00

J/E XREF:

Dept 99173

VENDOR: OUHSC COLLEGE OF PUBLIC HEALTH
ADDRESS: SCB ROOM 116
ADDRESS: P O BOX 26901
CITY/ST/ZIP: OKLA CITY OK 73190

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

12/14/98
Date

Agency, Bd or Div. Use

PM

The University of Oklahoma

Health Sciences Center

DEPARTMENT OF OCCUPATIONAL AND ENVIRONMENTAL HEALTH

INVOICE - Revised

BILL TO: Oklahoma State Department of Health
ATTN: Account Payable
1000 Northeast 10th Street, Room 903
Oklahoma City, Oklahoma 73117-1212

Invoice Date: December 1, 1998
Invoice No.: 02

P.O. Number: S039793

Item No.	Quantity	Unit	Description of Materials	Unit Cost	Total
1	1	Ea	Registration Fee for Ms. Susan A. Waldron to attend the Lead-Based Paint Inspector Seminar, November 16-18, 1998. Janice M. Linn did not attend.	$ 395.00	$ 395.00

REMIT PAYMENT TO: University of Oklahoma Health Sciences Center
Institute for Environmental Management
College of Public Health
Post Office Box 26901, Room 413
Oklahoma City, Oklahoma 73190

The undersigned hereby certifies that all payments requested are for appropriate purposes and in accordance with the agreement.

RECEIVED
DEC 07 1998
Personal Health Finance

Mark R. Cox, Ph.D., Interim Director
Institute for Environmental Management

$ 395.00

S039793	009935NW
PO# or CT#	Account Nu
/ / /	400BT99
Complete-Partial	Fund N
42000	3911A-X
Sub-Activity	Object
/ / /	
Math Entered	Claim Nu
THICKS	12/8/98
INV Funded By	Date

Invoice Prepared by Carolyn J. Scott
(405) 271-2070

College of Public Health • Post Office Box 26901 • 801 Northeast 13th, Room 413
Oklahoma City, Oklahoma 73190 • (405) 271-2070 • FAX (405) 271-1971

Financial Management Service

Return#: 2626

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To:

Personal Health

Vendor Name: OUHSC **Vendor Number:**

Invoice Number 02 **Invoice Date:** 12/1/98 **Amount** $395.00

Order Number S039793 **Audited By** Tom Lopo **Date Rejected:** 12/7/98

Funding

- ☑ Funding Not Indicated
- ☐ Does Not Match Encumbrance
- ☐ Invalid Fund
- ☐ Invalid Account
- ☐ Invalid Sub-Activity
- ☐ Invalid Object Code

Signature

- ☐ Vendor Signature
- ☐ Supervisor Signature
- ☐ Funding Block Signature

Verify The Following:

- ☐ Verify Vendor FEI #
- ☐ Verify Order #

Not Enough Allotment:

- ☐ 1st Quarter Allotment Insufficient
- ☐ 2nd Quarter Allotment Insufficient
- ☐ 3rd Quarter Allotment Insufficient
- ☐ 4th Quarter Allotment Insufficient

Need Additional Information:

- ☐ Certified Invoice Copy
- ☐ Proof of Delivery
- ☐ Notary Seal Missing
- ☐ Notary Signature Missing
- ☐ Notary County or State Incomplete
- ☐ Notary Expired (Not Valid)
- ☐ Changes Need Justification
- ☐ Changes Need Authorizing Initials
- ☐ Item Not Found

Mathematical Errors:

- ☐ Calculations Inaccurate
- ☐ Cross Footing Inaccurate
- ☐ Price Discrepancy

Encumbrance Problem:

- ☐ Invoice Exceeds Contract
- ☐ Invoice Exceeds Encumbrance
- ☐ Order Finalled

Required Dates:

- ☐ Invoice Date Prior to Date of Service
- ☐ Notary Date Prior to Date of Invoice
- ☐ Notary Date Prior to Date of Service

Other Remarks or Comments:

Division Finance Area Comments

Lead Based Paint
NW

OK-TRH 12/8/98

RECEIVED
DEC 07 1998
Personal Health Finance

Please Return This Document To Financial Management

FILENAME: OTTAWA CO. LEAD POISON PREV.

Prepared By: GDS
12-23-1998

TIME AND EFFORT
COST ACCUMULATION SCHEDULE

GRANT NAME: CDC\CONDUCT SITE-SPECIFIC ACTIVITIES
GRANT NUMBER: U50/ATU886520-01
BUDGET PERIOD: 09/29/98 TO 09/28/99
PGM CODE : 391

	== PROGCOST ==				== 244 OTHER ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	2 69	3 43	-	19 74	-	-	-	-
NOVEMBER	17 50	33 13	-	155 18	-	-	-	-
DECEMBER	23 92	44.75	-	179 66	-	-	-	-
JANUARY 99	36 23	36 09	-	192 94	-	-	-	-
FEBRUARY	25 87	29 17	-	154.37	-	-	-	-
MARCH	40 98	42 65	-	212 25	-	-	-	-
APRIL	32.19	48 20	-	216.33	-	-	-	-
MAY	29 01	45 17	-	303 87	-	-	-	-
JUNE	39 18	39 55	-	366 62	-	-	-	-
JULY	20.41	49 95	-	116 29	-	-	-	-
AUGUST	32.43	51 31	-	269 15	-	-	-	-
SEPTEMBER	31 66	39 62	-	480 50	-	-	-	-
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	354.07	463 72	-	2,888 90	-	-	-	-

	== 301 OTHER ==				== TOTAL ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	0 52	0.66	-	3 79	3 21	4 09	-	23 53
NOVEMBER	2 46	4 65	-	21.79	19 96	37 78	-	176.97
DECEMBER	3 00	5 62	-	22 57	26 92	50 37	-	202 23
JANUARY 99	5 48	5 17	-	27 84	43 71	41 26	-	220.56
FEBRUARY	3 43	3 86	-	20 46	29 30	33 03	-	174 83
MARCH	4 56	4.75	-	23 63	45 54	47.40	-	235 86
APRIL	3 83	5.73	-	25.74	36 02	53 93	-	242 07
MAY	3.14	4.89	-	32 93	32 15	50 06	-	336 80
JUNE	4 55	4 59	-	42 56	43 73	44 14	-	409 18
JULY	2 14	5 24	-	12 19	22 55	55 19	-	128 48
AUGUST	3 19	5 05	-	28 48	35 62	56 38	-	317.61
SEPTEMBER	3 53	4 44	-	53 64	35 19	44 26	-	534 14
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	39 83	54.85	-	315 40	373 90	517.87	-	[illegible]

	TOTAL NON-PAYROLL
JULY 98	-
AUGUST	-
SEPTEMBER	-
OCTOBER	30 83
NOVEMBER	234.71
DECEMBER	279 52
JANUARY 99	305 55
FEBRUARY	237.16
MARCH	326 82
APRIL	332 02
MAY	419 01
JUNE	497 05
JULY	208 22
AUGUST	409 59
SEPTEMBER	813 59
OCTOBER	-
NOVEMBER	-
DECEMBER	-
TOTAL	5,694.07

WORKMANS COMPENSATION

Fund	Account	Sub-Act	Obj Code	Desription	Ref #	Date	Amount	Vendor #
400BT99	009935NW97	42000	1231	W/C ,WALDRON	C42056	19990102	28.12	
400BT99	009935NW97	42000	1231	WC/	C72316	19990403	30.36	
400BT99	009935NW97	42000	1231	WC/	C72942	19990501	48.9	
400BT99	009935NW97	42000	1231	WC/	C78314	19990605	48.9	
400BT99	009935NW97	42000	1231	WC/	C86433	19990703	48.9	
400BT99	009935NW97	42000	1231	WC/	C88551	19990807	48.9	
							254.08	

PERSONAL IDENTIFIER(S) REDACTED

WORKMANS COMPENSATION

Fund	Account	Sub-Act	Obj Code	Description	Ref#-	Date	Amount	Vendor #
400BT90	000035NW97	42000	1231	WC/	D00355	19990904	50	
400BT90	000035NW97	42000	1231	WC/	D12092	19990904	-50	
400BT90	000035NW97	42000	1231	WC/	D06809	19991002	47.59	
400BT90	000035NW97	42000	1231	WC/	D09320	19991002	-22.84	
400BT90	000035NW97	42000	1231	WC/	D15077	19991106	96.14	
400BT90	000035NW97	42000	1231	WC/	D19759	19991106	-96.14	
400BT90	000035NW97	42000	1231	WC/	D22163	19991106	48.07	
							72.82	

PERSONAL IDENTIFIER(S) REDACTED

SCHEDULE I
INDIRECT COSTS CALCULATION
CONDUCT SITE-SPECIFIC ACTIVITIES
09/29/98 to 09/28/99

	BASE	RATE	AMOUNT
ON-SITE			
FFY 1999	$ 447.57	22.90%	$ 102.49
FFY 2000	345.80	16.70%	57.75
OFF-SITE			
FFY 1999	$ 19,244.97	15.00%	$ 2,886.75
FFY 2000	$ 10,960.97	14.70%	1,611.26
		TOTAL INDIRECT COSTS	$ 4,658.25
		TOTAL FEDERAL SHARE	$ 4.658.25

PERSONAL IDENTIFIER(S) REDACTED

TOTAL SALARY	TOTAL FRINGE
-	-
-	-
-	-
193.53	76.94
1,151.22	457.61
1,530.74	603.55
1,815.13	692.39
1,700.89	655.27
2,602.08	841.14
2,617.49	845.30
4,659.99	1,380.04
3,421.47	1,068.43
3,094.12	890.10
3,716.24	1,048.62
4,496.41	1,204.37
-	-
-	-
-	-
30,999.31	9,763.76

ON-SITE INDIRECT COSTS CALCULATION	
SFY 1 SALARIES	447.57
SFY 1 IDC RATE	22.9%
EQUALS	102.49
SFY 2 SALARIES	345.80
SFY 2 IDC RATE	16.7%
EQUALS	57.76
TOTAL IDC	4,668.26

OFF-SITE INDIRECT COSTS CALCULATION	
SFY1 SALARIES	19,244.97
SFY1 IDC RATE	15.0%
EQUALS	2,886.75
SFY2 SALARIES	10,960.97
SFY 2 IDC RATE	14.7%
EQUALS	1,611.26

STATE AND LOCAL RATE AGREEMENT

EIN #: 17360179870C4

DATE: June 5, 1998

DEPARTMENT/AGENCY:
Oklahoma State Department of Health
P.O. Box 53551
1000 NE Tenth St.
Oklahoma City OK 73117-1299

FILING REF.: The predecessor Agreement was dated July 31, 1997

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE(%)	LOCATIONS	APPLICABLE TO
FIXED	07/01/98	06/30/99	22.9	On Site	All Programs
FIXED	07/01/98	06/30/99	15.0	Off Site	All Programs
PROV.	07/01/99	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending June 30, 1999.		

New Rate
7/1/99 6/30/2000 16.7% on-site
14.7% off-site

*BASE:
Direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits.

STATE AND LOCAL RATE AGREEMENT

EIN #: 1736017987C4

DATE: May 24, 1999

DEPARTMENT/AGENCY:
Oklahoma State Department of Health
P.O. Box 53551
1000 NE Tenth St.
Oklahoma City OK 73117-1299

FILING REF.: The preceding Agreement was dated June 5, 1998

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE(%)	LOCATIONS	APPLICABLE TO
FIXED	07/01/99	06/30/00	16.7	On Site	All Programs
FIXED	07/01/99	06/30/00	14.7	Off Site	All Programs
PROV.	07/01/00	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending June 30, 2000.		

*BASE:
Direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits.

FILENAME: OTTAWA CO. LEAD POISON PREV.

Prepared By: GDS
12-23-1999

TIME AND EFFORT
COST ACCUMULATION SCHEDULE

GRANT NAME: CDC\CONDUCT SITE-SPECIFIC ACTIVITIES
GRANT NUMBER: U50/ATU686520-01
BUDGET PERIOD: 09/29/98 TO 09/28/99
PGM CODE : 391

	== TE009 ==				== PGM 244 ==			
	ON-SITE SALARY	ON-SITE FRINGE	OFF-SITE SALARY	OFF-SITE FRINGE	ON-SITE SALARY	ON-SITE FRINGE	OFF-SITE SALARY	OFF-SITE FRINGE
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	-	-	146.39	61.56	-	-	-	-
NOVEMBER	6.52	2.23	885.76	372.53	-	-	-	-
DECEMBER	-	-	1,158.43	485.84	-	-	-	-
JANUARY 99	61.53	20.61	1,374.19	553.97	-	-	-	-
FEBRUARY	82.92	25.62	1,355.25	547.16	-	-	-	-
MARCH	75.38	23.30	2,223.08	722.92	-	-	-	-
APRIL	45.27	14.00	2,245.31	730.75	-	-	-	-
MAY	90.47	27.96	4,156.05	1,221.02	-	-	-	-
JUNE	25.14	7.78	3,040.09	951.55	-	-	-	-
JULY	25.63	7.23	2,763.05	797.86	-	-	-	-
AUGUST	313.57	76.74	3,097.23	886.87	-	-	-	-
SEPTEMBER	-	-	4,084.43	1,089.15	-	-	-	-
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	726.43	205.47	26,529.26	8,420.78	-	-	-	-

TE009 + PGM 301 = TOTAL

FILENAME: OTTAWA CO. LEAD POISON PREV.

Prepared By: GDS 12-23-1999

TIME AND EFFORT
COST ACCUMULATION SCHEDULE

GRANT NAME: CDC\CONDUCT SITE-SPECIFIC ACTIVITIES
GRANT NUMBER: U50/ATU886520-01
BUDGET PERIOD: 09/29/98 TO 09/28/99
PGM CODE : 391

	== PROGCOST ==				== 244 OTHER ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	2 69	3 43	-	19 74	-	-	-	-
NOVEMBER	17 50	33 13	-	155.18	-	-	-	-
DECEMBER	23 82	44 75	-	179 66	-	-	-	-
JANUARY 99	36 23	38 09	-	192 84	-	-	-	-
FEBRUARY	25 87	29 17	-	154 37	-	-	-	-
MARCH	40 98	42 65	-	212 25	-	-	-	-
APRIL	32 19	46 20	-	216 33	-	-	-	-
MAY	29 01	45 17	-	303 67	-	-	-	-
JUNE	39 18	39 55	-	366 62	-	-	-	-
JULY	20 41	49 95	-	116 29	-	-	-	-
AUGUST	32 43	51.31	-	289 15	-	-	-	-
SEPTEMBER	31 88	39 82	-	480 50	-	-	-	-
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	334 07	463 22	-	2,894 90	-	-	-	-

	== 301 OTHER ==				== TOTAL ==			
	FEES	TRAVEL	EQUIP	OTHER	FEES	TRAVEL	EQUIP	OTHER
JULY 98	-	-	-	-	-	-	-	-
AUGUST	-	-	-	-	-	-	-	-
SEPTEMBER	-	-	-	-	-	-	-	-
OCTOBER	0 52	0 66	-	3 79	3 21	4 09	-	23 53
NOVEMBER	2 46	4.65	-	21 79	19 96	37.78	-	176 97
DECEMBER	3 00	5 62	-	22 57	26 92	50 37	-	202 23
JANUARY 99	5 48	5 17	-	27 84	43 71	41.26	-	220.68
FEBRUARY	3 43	3 86	-	20 46	29 30	33 03	-	174.83
MARCH	4 56	4.75	-	23 83	45 54	47 40	-	235 88
APRIL	3 83	5.73	-	25 74	36 02	53 93	-	242 07
MAY	3 14	4 89	-	32 93	32 15	50 06	-	336 60
JUNE	4 55	4 58	-	42 56	43 73	44.14	-	409.18
JULY	2 14	5 24	-	12 19	22 55	55 19	-	128.48
AUGUST	3.19	5 05	-	26 48	35 62	56 38	-	317.81
SEPTEMBER	3 53	4 44	-	53 64	35 19	44 26	-	534.14
OCTOBER	-	-	-	-	-	-	-	-
NOVEMBER	-	-	-	-	-	-	-	-
DECEMBER	-	-	-	-	-	-	-	-
TOTAL	36 63	54 85	-	315 40	373 90	617 87	-	3,809 90

	TOTAL NON-PAYROLL
JULY 98	-
AUGUST	-
SEPTEMBER	-
OCTOBER	30 83
NOVEMBER	234 71
DECEMBER	279 52
JANUARY 99	305 55
FEBRUARY	237.16
MARCH	328 82
APRIL	332 02
MAY	419 01
JUNE	497.05
JULY	206 22
AUGUST	409 59
SEPTEMBER	613 59
OCTOBER	-
NOVEMBER	-
DECEMBER	-
TOTAL	3,894 07

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

DATE 6/26/2003

Oklahoma State Department of Health
State Cooperative Agreement Expenditures (SCA)
Superfund site (60BE), Tar Creek (Ottawa County) (OU2)
Ottawa County, Oklahoma

For the period 9/29/99 to 9/28/00

Personnel	**$**	**108,194.98**
Fees	**$**	**9,577.27**
Travel	**$**	**5,898.19**
Equipment	**$**	**16,170.32**
Other	**$**	**30,672.34**
Indirect	**$**	**11,002.21**
TOTAL OKLAHOMA SCA COSTS	**$**	**181,515.31**

PERSONAL IDENTIFIER(S) REDACTED

Oklahoma State Department of Health
Leslie M. Beitsch, MD
Commissioner of Health

June 11, 2003

Betty Jones
Cost Recovery Team Leader
1825 Century Boulevard
Mail Stop E-28 (OPOM)
Atlanta, Georgia 30345

RE: Tar Creek Documentation Requested for Cost Recovery (9/29/1999 to 9/28/2000)

Dear Ms. Jones,

In response to your request for Cost Recovery documentation I am sending you the enclosed information. This information covers the period 9/29/1999 to 9/28/2000 for the Program to Build Capacity to Conduct Site-Specific Environmental Health Education Monitoring Activities.

I have this documentation grouped with the same categories identified in the letter from Ken Cadaret to Richard Haj dated June 6, 2002. I have included all costs for this period that we can support with documentation.

If you have any additional question regarding the documentation provided please feel free to contact me at (405) 271-4042.

Respectfully,

Michael D. Truitt
Grants Supervisor
Financial Management Service

Board of Health
Ron L. Graves, DDS, President
John B. Carmichael, DDS
Jay A. Gregory, MD
Haskell L. Evans, Jr. RPh, Vice President
Gordon H. Deckert, MD
Ron Osterhout
Glen E. Diacon, Jr. MD, -Treasurer
Dan H. Fieker, DO
Ann A. Warn, MD

1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us

PERSONNEL

9/29/1999 to 9/28/2000

TE005	97,731.42
PGM 301	11,652.57
Sub-Total	109,383.99
Adjustments to TE005	(1,189.01)
Total Personnel	$ 108,194.98

TE005 are the direct costs and PGM 301 are the allocated costs. PGM 301 is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

Time And Effort Cost Accumulation Schedule

December 27, 2000

Prepared By _____

Grant Name: Conduct Site Specific Activity **Grant Period:** 09/29/1999 TO 09/28/2000

Grant Number: U50 / ATU686520-02 **Program Code:** 391

	TE686				PGM 244					
Year\Month	On-Salary	On-Fringe	Off-Salary	Off-Fringe	On-Salary	On-Fringe	Off-Salary	Off-Fringe	Total Salary	Total Fringe
199910	138.38	38.99	2,961.13	856.17	0.00	0.00	0.00	0.00		
199911	20.51	5.78	5,236.90	1,464.24	0.00	0.00	0.00	0.00		
199912	732.83	190.81	6,202.21	1,751.08	0.00	0.00	0.00	0.00		
200001	512.24	134.59	6,168.13	1,867.44	0.00	0.00	0.00	0.00		
200002	464.02	120.77	7,477.05	2,209.84	0.00	0.00	0.00	0.00		
200003	438.78	116.58	6,433.11	1,790.98	0.00	0.00	0.00	0.00		
200004	602.31	159.40	4,854.16	1,393.71	0.00	0.00	0.00	0.00		
200005	568.67	150.91	4,872.57	1,394.10	0.00	0.00	0.00	0.00		
200006	392.13	103.27	5,854.30	1,645.18	0.00	0.00	0.00	0.00		
200007	515.27	150.99	6,030.77	1,814.16	0.00	0.00	0.00	0.00		
200008	498.75	141.83	7,733.73	2,251.46	0.00	0.00	0.00	0.00		
200009	509.25	148.68	6,812.51	2,000.75	0.00	0.00	0.00	0.00		
Total	**5,393.14**	**1,462.60**	**70,636.57**	**20,239.11**	**0.00**	**0.00**	**0.00**	**0.00**		
	PGM301				TOTAL					
199910	23.33	6.15	430.43	123.70	161.71	45.14	3,391.56	979.87	3,553.27	1,025.01
199911	3.57	0.96	532.26	150.43	24.08	6.74	5,769.16	1,614.67	5,793.24	1,621.41
199912	84.11	22.35	714.27	203.96	816.94	213.16	6,916.48	1,955.04	7,733.42	2,168.20
200001	85.58	23.48	1,049.41	302.13	597.82	158.07	7,217.54	2,169.57	7,815.36	2,327.64
200002	53.32	14.25	853.40	246.89	517.34	135.02	8,330.45	2,456.73	8,847.79	2,591.75
200003	60.80	16.03	656.13	187.62	499.58	132.61	7,089.24	1,978.60	7,588.82	2,111.21
200004	76.91	20.57	528.90	149.42	679.22	179.97	5,383.06	1,543.13	6,062.28	1,723.10
200005	75.09	20.01	579.23	164.93	643.76	170.92	5,451.80	1,559.03	6,095.56	1,729.95
200006	47.85	13.69	574.75	165.10	439.98	116.96	6,429.05	1,810.28	6,869.03	1,927.24
200007	54.64	15.07	732.27	209.33	569.91	166.06	6,763.04	1,823.49	7,332.95	1,989.55
200008	58.47	16.09	1,007.03	281.09	557.22	157.92	8,740.76	2,532.55	9,297.98	2,690.47
200009	58.06	16.36	733.22	209.93	567.31	165.04	7,545.73	2,210.68	8,113.04	2,375.72
Total	**681.73**	**185.61**	**8,391.39**	**2,394.63**	**6,074.87**	**1,647.61**	**79,027.87**	**22,633.64**	**86,102.74**	**24,281.25**

→ $11,652.57
301 Allocation

Adjustments to TE005 Report
9/29/1999 to 9/28/2000

The following are costs for which there are no supporting documents:

		Total Hours	Total Cost	Per Hour Rate	Hours (Short)/Long	Cost Adjustment
1	Cadaret, K.	173.65	5,170.09	29.77	0.34	**10.12**
2	Fouquet, S.	72.65	1,638.31	22.55	1.34	**30.22**
3	Hartsell, H.	1.00	47.34	47.34	(1.00)	**(47.34)**
4	Horton, N.	1,734.33	36,274.57	20.92	(25.00)	**(523.00)**
4	Nichols, J.	62.68	2,036.34	32.49	(16.00)	**(519.84)**
5	Owens, Q.	2.00	44.43	22.22	(2.00)	**(44.44)**
6	Waldron, S.	1,877.36	34,946.36	18.61	(1.00)	**(18.61)**
7	Williams, K.	4.67	133.16	28.51	(2.67)	**(76.12)**
						$ (1,189.01)

REPORT-ID=TE005 — OKLAHOMA DEPARTMENT OF HEALTH — DATE RUN 06/04/2003

ALPHA SORT — LABOR DISTRIBUTION REPORT(PROGRAM CODE 391 ONLY) — PAGE 1

PERIOD 10/01/1999 THRU 09/30/2000

NAME (LAST)	F	PROG	ACT	TASK	OUT	SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
BUSHERS	J	391	020				41.00	19.46	60.46	32.9	433.54	175.30	608.84
		391	021				150.34	83.27	233.61	67.1	1702.25	688.30	2390.55
SUBTOTAL		391					191.34	102.73	294.07	100.0	2135.79	863.60	2999.39
TOTAL							191.34	102.73	294.07	100.0	2135.79	863.60	2999.39
CADARET	K	391	021				173.65	30.89	204.54	100.0	4073.40	1096.69	5170.09
TOTAL							173.65	30.89	204.54	100.0	4073.40	1096.69	5170.09
CORNELL	K	391	010	001			36.99	10.76	47.75	26.3	1057.32	259.91	1317.23
		391	010	002			4.00	0.22	4.22	2.3	78.64	19.82	98.46
		391	411	001		4	41.67	5.48	47.15	26.0	1146.71	276.24	1422.95
		391	412	001			0.67	0.07	0.74	0.4	14.30	3.59	17.89
		391	426	001			27.33	7.18	34.51	19.0	778.22	190.50	968.72
		391	426	002			3.67	0.29	3.96	2.2	138.60	30.88	169.48
		391	427	002			13.00	5.69	18.69	10.3	364.63	91.76	456.39
		391	431	001		12	61.67	9.61	71.28	39.2	1542.23	384.25	1926.48
		391	441	001			6.36	1.15	7.51	0.0	160.90	40.52	201.42
SUBTOTAL		391					195.36	40.45	235.81	125.7	5281.55	1297.47	6579.02
TOTAL							195.36	40.45	235.81	125.7	5281.55	1297.47	6579.02
DURBOROW	K	391	010				0.67	0.06	0.73	100.0	7.41	2.46	9.87
TOTAL							0.67	0.06	0.73	100.0	7.41	2.46	9.87
FOUQUET	S	391	021				72.65	12.66	85.31	100.0	1281.57	356.74	1638.31
TOTAL							72.65	12.66	85.31	100.0	1281.57	356.74	1638.31
FROST	T	391	010				21.97	2.99	24.96	14.2	513.65	128.92	642.57
		391	020				49.34	6.58	55.92	31.8	1155.71	289.85	1445.56
		391	021				67.70	8.71	76.41	54.0	1570.26	394.05	1964.31
SUBTOTAL		391					139.01	18.28	157.29	100.0	3239.62	812.82	4052.44
TOTAL							139.01	18.28	157.29	100.0	3239.62	812.82	4052.44
HARTSELL JR	H	391	101	616			1.00	0.25	1.25	100.0	38.17	9.17	47.34
TOTAL							1.00	0.25	1.25	100.0	38.17	9.17	47.34
HASHEMIPOUR	P	391	021				1.34	0.00	1.34	100.0	10.11	0.77	10.88
TOTAL							1.34	0.00	1.34	100.0	10.11	0.77	10.88
HOPKINS	T	391	010				15.63	0.02	15.65	9.6	100.65	19.45	120.10
		391	020				367.66	10.25	377.91	231.8	2584.96	916.25	3501.21
		391	021				18.68	0.22	18.90	0.0	123.22	44.69	167.91
SUBTOTAL		391					401.97	10.49	412.46	241.4	2808.83	980.39	3789.22
TOTAL							401.97	10.49	412.46	241.4	2808.83	980.39	3789.22
HORTON	N	391	010				62.29	4.92	67.21	32.6	989.70	274.69	1264.39

PERSONAL IDENTIFIER(S) REDACTED

REPORT-ID=TE005 OKLAHOMA DEPARTMENT OF HEALTH DATE RUN 06/04/2003
LABOR DISTRIBUTION REPORT(PROGRAM CODE 391 ONLY) PAGE 2
ALPHA SORT PERIOD 10/01/1999 THRU 09/30/2000

NAME (LAST)	F	PROG	ACT	TASK	OUT	SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
		391	020				1630.04	152.05	1782.09	865.1	26654.58	7398.43	34053.01
		391	021				42.00	5.84	47.84	0.0	752.25	204.92	957.17
SUBTOTAL		391					1734.33	162.81	1897.14	897.7	28396.53	7878.04	36274.57
TOTAL							1734.33	162.81	1897.14	897.7	28396.53	7878.04	36274.57
NICHOLS	J	391	001				58.01	13.90	71.91	42.8	1476.93	372.19	1849.12
		391	010				4.67	2.66	7.33	57.2	149.57	37.65	187.22
SUBTOTAL		391					62.68	16.56	79.24	100.0	1626.50	409.84	2036.34
TOTAL							62.68	16.56	79.24	100.0	1626.50	409.84	2036.34
OWENS	Q	391	021				2.00	0.11	2.11	100.0	34.06	10.37	44.43
TOTAL							2.00	0.11	2.11	100.0	34.06	10.37	44.43
WALDRON	S	391	010				156.02	12.39	168.41	91.5	2219.81	653.26	2873.07
		391	020				1501.65	142.80	1644.45	893.7	21635.98	6378.39	28014.37
		391	021				219.69	16.34	236.03	0.0	3138.59	920.33	4058.92
SUBTOTAL		391					1877.36	171.53	2048.89	985.2	26994.38	7951.98	34946.36
TOTAL							1877.36	171.53	2048.89	985.2	26994.38	7951.98	34946.36
WILLIAMS	K	391	020				4.67	1.51	6.18	100.0	101.79	31.37	133.16
TOTAL							4.67	1.51	6.18	100.0	101.79	31.37	133.16
GRAND TOTAL							4,858.03	568.33	5,426.36	100.0	76,029.71	21,701.71	97,731.42

Time and Effort (T&E) Sheet

Page 5

Employee Jennifer Bushers

Month 12 Year 99

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	[redacted]	391	021		04	00	058						
2	27	216	021		02	00	058						
3	27	216	020		02	00	058						
4	[redacted]	391	020		06	00	058						
5	[redacted]	391	021		02	00	058						
6	[redacted]	391	020		06	00	058						
7	[redacted]	391	021		02	00	058						
8	30	216	020		04	00	058						
9	30	216	021		04	00	058						
10	31	301	009		08	00	058						
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols
JNB

ODH Form 4

Time and Effort (T&E) Sheet

Page 1

Employee Jennifer Bushers

Month 01 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	[redacted]				0	0	058						
2	03	30	021		02	00	058						
3	[redacted]				08	00	058						
4	05	30	021		06	00	058						
5	05	30	1003		02	00	058						
6	[redacted]				08	00	058						
7	[redacted]				07	00	058						
8	07	30	1003		01	00	058						
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ENTERED
FEB 2 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols NLB

ODH Form 4

Time and Effort (T&E) Sheet

Page 2

Month 01 Year 00

Employee Jennifer Bushers

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	301	004		08	00	058						
2	11	301	004		08	00	058						
3	[redacted]		021		05	80	058						
4	12	301	004		02	40	058						
5	13	301	004		08	00	058						
6	14	301	004		08	00	058						
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ENTERED
FEB 2 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols
LNB

ODH Form 4

Time and Effort (T&E) Sheet

Page 3

Month 01 Year 00

Employee Jennifer Bushers

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	3011	009		08	00	058						
2	18	3911	020		02	00	058						
3	18	3911	021		06	00	058						
4	19	3911	021		08	00	058						
5	20	2666	020		04	00	058						
6	20	2666	021		04	00	058						
[redacted]		3911	021		08	00	058						
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ENTERED
MAR 21 2000

TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Jennifer Bushers

Month 01 Year 00

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	266	020		03	00	058						
2	24	266	021		03	00	058						
3	[illegible]	391	021		02	00	058						
4	[illegible]	391	020		03	00	058						
5	[illegible]	391	021		05	00	058						
6	[illegible]	391	020		02	00	058						
7	[illegible]	391	021		06	00	058						
8	27	266	020		03	00	058						
9	27	266	021		03	00	058						
10	[illegible]	391	021		02	00	058						
11	[illegible]	391	021		08	00	058						
12													
13													
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16													
17										ENTERED			
18										MAR 21 2000			

TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Jennifer Bushers

Month 01 Year 00

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	[redacted]	266	021		04	00	058						
2	31	262	021		02	00	058						
3	31	266	020		02	00	058						
4													
5													
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ENTERED
MAR 21 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols MLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Jennifer Bushers

Social Security Number –PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	021		08	00	058						
2	02	391	021		05	00	058						
3	02	391	020		03	00	058						
4	03	391	021		02	00	058						
5	03	391	020		02	00	058						
6	03	266	021		02	00	058						
7	03	266	020		02	00	058						
8	04	391	021		08	00	058						
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ENTERED
MAY 24 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols LMB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Jennifer Bushers

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	266	020		01	00	058						
2	07	266	021		01	00	058						
3	07	391	020		03	00	058						
4	07	391	021		03	00	058						
5	08	301	004		03	00	058						
6	09	391	021		05	00	058						
7	09	391	021		04	00	058						
8	09	391	020		04	00	058						
9	10	266	020		03	00	058						
10	10	266	021		03	00	058						
11	10	391	021		02	00	058						
12	11	391	021		08	00	058						
13													
14													
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16										ENTERED			
17										MAY 24 2000			
18										TIME & EFFORT			

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Jennifer Bushers

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	1 4	391	020		02	00	058						
2	1 4	391	021		02	00	058						
3	1 4	266	020		02	00	058						
4	1 4	266	021		02	00	058						
5	1 5	301	003		02	00	058						
6	1 5	391	021		06	00	058						
7	1 6	391	021		08	00	058	by SW					
8	1 7	301	002		08	00	058	by SW					
9	1 8	301	004		08	00	058	by SW					
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jennifer Bushers

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1 of 5

Employee Ken Cadaret

Month 12 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	383	021		08	00							
2	02	383	021		02	00							
3	02	391	021		06	00							
4	03	324	021		08	00							
5													
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ENTERED
FEB 10 2000
TIME & E

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Ken Cadaret

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2 of 5

Employee Ken Cadaret

Month 12 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	301	003		08	00							
2	07	383	021		08	00							
3	08	383	021		02	00							
4	08	391	021		06	00							
5	09	324	021		08	00							
6	10	324	021		08	00							
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ENTERED
FEB 10 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [illegible]

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3 of 5

Employee Ken Cadaret

Month 12 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	383	021		08	00							
2	14	301	002		08	00							
3	15	383	021		02	00							
4	15	391	021		06	00							
5	16	324	021		08	00							
6	17	324	021		08	00							
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ENTERED
FEB 10 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	383	021		08	00							
2	21	383	021		02	00							
3	21	391	021		06	00							
4	22	301	002		08	00							
5	23	301	002		08	00							
6	24	301	009		08	00							
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ENTERED
FEB 10 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	383	021		08	00							
2	28	383	021		02	00							
3	28	391	021		06	00							
4	29	324	021		08	00							
5	30	301	002		08	00							
6	31	301	009		08	00							
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ENTERED
FEB 10 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [illegible]

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	391	021		04	00							
2	03	383	021		04	00							
3	04	383	021		06	00							
4	04	324	021		03	00							
5	05	324	021		07	40							
6	06	324	021		09	00							
7	07	324	021		07	00							
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ENTERED
MAR 21 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [illegible]

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 26

Employee Ken Cadaret

Month 01 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	338	021		04	00							
2	10	383	021		03	40							
3	11	383	021		06	20							
4	11	324	021		02	40							
5	12	324	021		07	40							
6	13	324	021		09	00							
7	14	324	021		08	40							
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16										FEB 29 2000			
17										TIME & EFFORT			
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature Marie [illegible]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee [redacted]

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	3C1	C0A		C	80							
2	18	3A1	C2		C	40							
3	18	383	C2		C	50							
4	19	383	C2		C	50							
5	19	324	C2		C	70							
6	20	324	C2		C	84							
7	21	324	C2		0	50							
8	22	324	C2		7	70							
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18													

ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [redacted]

Supervisor's Signature [redacted]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 5

Employee Ken Ladaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	383	021		04	00							
2	24	391	021		04	00							
3	24	383	021		05	00							
4	25	383	021		08	00							
5	26	383	021		09	00							
6	27	383	021		10	00							
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ENTERED
APR 5 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5 of 5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	31	301	021		04	00							
2	31	383	021		04	00							
3													
4													
5													
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ENTERED
APR 5 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	301	003		08	00							
2	08	391	021		04	00							
3	08	383	021		04	20							
4	09	383	021		05	40							
5	09	324	021		02	20							
6	10	324	021		04	40							
7	11	324	021		12	00							
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ENTERED
MAY 24 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Ken Codoret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	021		04	00							
2	14	383	021		04	00							
3	15	383	021		06	00							
4	15	324	021		03	00							
5	16	324	021		07	40							
6	17	324	021		09	00							
7	18	324	021		05	00							
8	18	301	002		01	20							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Codoret

Supervisor's Signature Marilyn Dougherty

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Kevin Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	301	009		08	00							
2	22	301	004		06	00							
3	23	391	021		04	00							
4	23	383	021		04	00							
5	24	383	021		06	00							
6	24	324	021		03	00							
7	25	324	021		09	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Kevin Cadaret

Supervisor's Signature Marilyn Doughty

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	383	021		04	00							
2	28	383	021		04	00							
3	29	383	021		06	00							
4	29	324	021		02	00							
5													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	021		04	00							
2	06	383	021		04	00							
3	07	383	021		06	00							
4	07	324	021		02	00							
5	08	324	021		08	00							
6	09	324	021		08	00							
7	10	324	021		08	00							
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ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	3911	021		04	00							
2	13	3831	021		04	00							
3	14	3831	021		06	00							
4	14	3241	021		02	40							
5	15	3241	021		08	20							
6	16	3011	002		05	00							
7	17	3241	021		10	00							
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9													
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ENTERED
JUN 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	324	021		06	00							
2	20	391	021		04	00							
3	20	383	021		04	00							
4	21	383	021		06	00							
5	21	324	021		02	00							
6	22	324	021		08	00							
7	23	324	021		08	00							
8	24	324	021		08	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature Marilyn Dougherty

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	324	021		04	00							
2	27	324	021		04	00							
3	27	383	021		02	00				ENTERED			
4	28	363	021		08	00							
5	24	324	021		09	00							
6	30	324	021		08	00							
7	31	324	021		09	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1 of 4

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	324	021		10	00							
2	03	391	021		04	00							
3	03	383	021		04	00							
4	04	383	021		06	00							
5	04	324	021		03	00							
6	05	324	021		08	00							
7	06	324	021		08	00							
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ENTERED
JUL 0 3 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [illegible]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2/4

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	021		04	00							
2	10	383	021		06	00							
3	11	383	021		04	00							
4	11	324	021		04	00							
5	12	324	021		09	40							
6	13	324	021		06	00							
7	14	301	002		06	20							
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ENTERED
JUN 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3/4

Employee Kem Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	3891	021		04	00							
2	17	383	021		04	00							
3	18	383	021		06	00							
4	18	324	021		02	00							
5	19	324	021		08	00							
6	20	324	021		08	00							
7	21	324	021		07	00							
8	21	3010	0002		01	00							
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ENTERED
JUN 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K - Cadaret

Supervisor's Signature Marilyn Daugherty

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/4

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	021		04	00							
2	24	383	021		02	40							
3	25	383	021		07	20							
4	25	324	021		00	40							
5	26	324	021		12	00							
6	27	324	021		08	00							
7	28	324	021		03	00							
8	28	301	003		02	20							
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ENTERED
JUL 11 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1 of 5

Employee Ken Cadaret

Month 05 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	394	021		04	00							
2	01	383	021		05	00							
3	02	383	021		09	00							
4	03	383	021		06	00							
5	03	324	021		03	00							
6	04	324	021		09	00							
7	05	324	021		09	00							
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ENTERED
AUG 01 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature Marilyn Dougherty

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Kear Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	383	021		08	00							
2	09	383	021		08	00							
3	10	324	021		05	00							
4	10	301	002		03	00							
5	11	391	021		04	00							
6	11	383	021		04	00							
7	12	324	021		04	00							
8	12	301	002		04	00							
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ENTERED
AUG 01 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Ken Cadaret

Month 05 Year 00

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	15	3941	021		04	00							
2	15	3833	021		04	00							
3	16	3833	021		04	00							
4	17	3833	021		04	00							
5	17	3011	002		03	00							
6	18	3833	021		04	00							
7	18	3241	021		04	00							
8	19	3241	021		09	00							
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ENTERED
AUG 0 1 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	39	102	1	04	00							
2	22	383	021		04	00							
3	23	383	021		09	40							
4	24	383	021		07	40							
5	25	324	021		07	40							
6	26	324	021		08	00							
7	27	324	021		08	00							
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ENTERED
AUG 04 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5/6

Employee Ken Cadaret

Month 05 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	301	009		08	00							
2	30	391	021		04	00							
3	30	383	021		04	00							
4	31	383	021		08	00							
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ENTERED
AUG 03 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature Marilyn Dougherty

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05/31/99	324	021		04	00							
2	05/24/99	324	021		04	00							
3	06/24/99	324	021		08	00							
4	07/24/99	324	021		04	00							
5	07/31/99	383	021		04	00							
6	08/31/99	383	021		08	00							
7	09/30/99	383	021		08	00							
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ENTERED
SEP 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Ken Cadaret

Supervisor's Signature [signature]

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12394	021			04	00							
2	12324	021			04	00							
3	13324	021			08	00							
4	14324	021			04	00							
5	14383	021			04	00							
6	15383	021			08	00							
7	16383	021			08	00							
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ENTERED
SEP 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	26	3911	021		04	00							
2	26	3833	021		04	00							
3	27	3833	021		06	00							
4	27	3241	021		02	00							
5	28	3241	021		08	00							
6	29	3241	021		06	00							
7	30	3241	021		04	00							
8	30	3010	0002		04	00							
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ENTERED
SEP 08 2008
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature Marilyn Dougherty

232

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

ENTERED
OCT 25 2000
TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	03	301	002		08	00							
2	04	301	009		08	00							
3	05	383	021		08	00							
4	06	383	021		08	00							
5	07	383	021		04	00							
6	07	391	021		04	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2/

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

ENTERED
OCT 25 2000
TIME & EFFORT

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	021		04	00							
2	10	383	021		04	00							
3	11	383	021		08	00							
4	12	383	021		08	00							
5	13	383	021		08	00							
6	14	383	021		05	00							
7	14	301	003		03	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

ENTERED
OCT 25 2000
TIME & EFFORT

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	021		04	00							
2	17	383	021		04	00							
3	18	383	021		08	00							
4	19	383	021		08	00							
5	20	301	002		08	00							
6	21	383	021		08	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

ENTERED OCT 25 2000

TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	24	391	021		04	00							
2	24	383	021		04	00							
3	25	383	021		08	00							
4	26	383	021		08	00							
5	27	383	021		08	00							
6	28	383	021		09	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature Marilyn Daughtry

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	39	021		04	00							
2	14	38	021		04	00							
3	15	38	021		04	00							
4	16	38	021		10	00							
5	17	38	021		12	00							
6	18	38	021		08	00							
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ENTERED
NOV 0 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	39	021		04	00							
2	21	38	021		04	00							
3	22	38	021		04	00							
4	22	301	004		03	00							
5	23	38	021		09	00							
6	24	38	021		12	00							
7	25	38	021		04	00							
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NOV 0 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Ken Cadaret

Supervisor's Signature Marilyn Dougherty

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	38	021		04	00							
2	28	38	021		04	00							
3	29	38	021		08	00							
4	30	38	010		06	00							
5	30	38	021		06	00							
6	31	38	021		08	00							
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ENTERED
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature SK

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	301	009		08	00							
2	05	391	021		04	00							
3	05	383	021		04	00							
4	06	383	021		07	00							
5	07	383	021		04	00							
6	08	383	021		04	00							
7	08	301	003		04	00							
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ENTERED
DEC 18 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature S. K.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Ken Padaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 9 Year 0 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	38	021		04	00							
2	11	383	021		04	00							
3	12	383	021		08	00							
4	13	383	021		08	00							
5	14	383	021		08	00							
6	15	383	021		08	00							
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ENTERED
DEC 18 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Padaret

Supervisor's Signature JK

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	383	021		04	00							
2	18	383	021		04	00							
3	19	383	021		08	00							
4	20	383	021		08	00							
5	21	383	021		06	00							
6	22	383	021		08	00							
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ENTERED
NOV 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5/5

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DEC 12

Month 09 Year 00

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	25	38	1	021	04	00							
2	25	38	3	021	04	00							
3	26	38	3	021	08	00							
4	27	38	3	021	09	00							
5	28	38	3	021	08	00							
6	29	38	3	021	04	00							
7	29	30	1	002	03	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J.K.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	289	426	001	04	00	001						
2	01	331	431	001	04	00	001						
3	02	331	431	001	01	00	001						
4	02	391	010	001	02	00	058						
5	02	391	426	001	05	00	058						
6	03	391	411	001	08	00	058						
7	04	391	431	001	06	00	058						
8	04	391	010	001	02	00	011						
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17													
18													

ENTERED
JUN 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL 002

Month 02 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	328	010	001	002	00	001						
2	07	328	426	001	01	40	001						
3	07	391	431	001	020	00	058						
4	07	331	441	001	04	00	001						
5	08	328	411	001	08	00	001						
6	09	328	431	001	04	00	001						
7	09	391	431	001	02	40	001						
8	09	301	003		01	20	001						
9	10	328	411	001	08	00	001						
10	11	331	010	001	02	00	061						
11	11	331	431	002	04	00	061						
12	11	331	010	001	02	00	001						
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ENTERED
JUN 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	331	010	001	00	20	001						
2	14	289	427	001	03	00	001						
3	14	331	431	001	04	40	001						
4	15	391	431	001	04	00	001						
5	15	331	431	001	04	00	001						
6	16	331	431	001	08	00	001						
7	17	331	431	001	08	00	001						
8	18	331	431	001	05	40	001						
9	18	301	002		02	20	001						
10													
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18													

ENTERED
MAY 24 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee KAREN K. CORVELL 002

Month 02 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	331	431	001	06	00	001						
2	28	391	431	001	01	00	058						
3	29	328	411	001	01	20	001						
4	29	331	431	001	01	20	001						
5	29	391	010	001	02	00	058						
6	29	391	431	001	04	20	058						
7													
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ENTERED
MAY 30 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Corvell

Supervisor's Signature J. Boggy

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 01

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	01	391	411	001	08	40	058						
2	01	391	010	001	00	20	058						
3	02	391	441	001	05	00	058						
4	02	391	431	001	03	40	058						
5	02	391	010	001	00	20	058						
6	03	391	431	001	05	00	058						
7	03	391	426	001	02	00	058						
8	03	391	010	001	02	00	011						
9													
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18													

ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 04

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	288	0101	001	00	40	001						
2	22	288	4288	001	02	00	001	008	001	17			
3	22	331	4311	001	05	20	001						
4	23	331	4311	001	06	00	001						
5	23	328	4311	001	02	00	001						
6	24	288	0101	001	00	40	001						
7	24	288	4288	001	08	20	001		001	17			
8	25	331	4311	001	04	00	001						
9	25	391	0102	002	02	00	058						
10	25	391	4272	002	03	00	058						
11	25	391	0102	002	02	00	011						
12	26	391	4311	001	02	00	058						
13	26	331	4311	001	03	00	001						
14	26	328	4311	001	00	20	001						
15													
16													
17													
18													

ENTERED
AUG 07 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	010	001	02	00	058						
2	12	391	411	001	08	00	058	002					
3	12	391	441	001	08	20	058						
4	13	391	010	001	00	40	058						
5	13	391	010	001	00	40	058						
6	13	391	426	001	01	00	058				ENTERED		
7	13	391	411	001	01	20	058	001			SEP 14 2000		
8	13	391	431	001	04	00	058				TIME & EFFORT		
9	14	391	010	001	00	20	058						
10	14	391	431	001	04	20	058						
11	15	391	411	001	04	00	058	001					
12	15	391	010	001	00	20	058						
13	15	391	427	002	04	40	058						
14	16	391	441	001	01	00	058						
15	16	391	431	001	05	00	058						
16	16	391	010	[redacted]	02	00	011						
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby by PLS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	331	431	001	08	00	001						
2	04	301	009		08	00	001						
3	05	331	431	001	08	00	001						
4	06	328	431	001	04	00	001	001					
5	06	391	431	001	04	00	058	001	12				
6	07	325	431	001	08	00	001	cc.					
7	07	391	010	001	02	00	058						
8	07	391	431	001	03	00	058						
9	07	391	010	001	02	00	01						
10													
11													
12													
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ENTERED
OCT 25 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL 002

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	331	441	001	03	00	001						
2	17	391	010	001	02	20	058						
3	17	391	412	001	00	40	058						
4	17	391	431	001	03	00	058						
5	18	391	426	001	06	00	058						
6	18	391	431	001	02	20	058						
7	19	391	010	001	02	20	001						
8	19	331	441	001	02	00	001						
9	19	331	431	001	04	40	001						
10	20	331	431	001	05	40	001						
11	21	331	431	001	08	00	001						
12													
13													
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ENTERED
OCT 25 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	328	010	001	02	00	061						
2	24	328	426	001	08	20	061						
3	25	328	426	001	06	20	061						
4	25	328	010	001	02	00	011						
5	26	391	426	001	00	20	058			ENTERED			
6	26	331	441	001	01	00	001			OCT 25 2000			
7	26	331	431	001	06	40	001			TIME & EFFORT			
8	27	331	431	001	06	00	001						
9	28	328	411	001	06	40	001						
10	28	301	003		04	00	001						
11													
12													
13													
14													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee KAREN B. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	331	431	00	0100		001						
2	01	391	431	001	0100		001						
3	01	391	0100	001	0200		058						
4	01	391	427	002	0520		058						
5	01	391	0100	001	0200		011						
6	02	331	431	001	0800		001			ENTERED			
7	03	331	0100	00[illegible]	0200		001			NOV 0 6 2000			
8	03	331	428	002	0600		001			TIME & EFFORT			
9	04	3258	0100	001	0220		021						
10	04	3258	411	001	0300		021						
11	04	331	431	001	0220		001						
12													
13													
14													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley by Pam Stephens

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	288	010	001	00	20	001						
2	07	288	427	001	05	00	001						
3	07	331	431	001	02	40	001						
4	08	288	010	001	00	20	001						
5	08	288	428	001	03	00	001	002	001	17			
6	08	331	431	001	01	40	001						
7	08	328	431	001	03	00	001						
8	09	328	411	001	08	00	001	001					
9	10	288	428	001	02	40	001	005	001	17 ENTERED			
10	10	391	431	001	01	00	058			NOV 0 0 2000			
11	10	328	431	001	02	20	001			TIME & EFFORT			
12	10	301	008		01	00	001						
13	11	391	010	001	02	00	058						
14	11	391	426	001	05	00	058						
15	11	391	010	001	02	00	011						
16													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley by Pam Stephens

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	301	009		08	00	001						
2	05	331	431	001	06	40	001						
3	05	391	010	001	02	00	058						
4	06	391	010	001	04	00	058			ENTERED			
5	06	391	411	001	09	40	058			NOV 2 8 2000			
6	07	391	010	001	04	00	058			TIME & EFFORT			
7	07	391	411	001	02	00	058						
8	07	391	431	001	03	20	058						
9	08	391	426	001	05	00	058						
10	08	391	010	001	02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jane Bagley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee KAREN K. CARNELL CC2

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	410	001	02	40	58						
2	18	391	426	002	03	40	58						
3	18	331	410	001	03	00	55						
4	18	331	441	001	01	40	55						
5	19	331	429	001	01	00	55						
6	19	331	428	002	07	00	55						
7	20	331	431	001	03	00	55						
8	20	288	428	001	02	00	55	068	001	17			
9	20	331	410	001	03	00	01						
10	21	328	426	001	01	00	00	1					
11	21	331	431	001	06	20	00	1					
12	22	301	002		20	00	00	1					
13	23	289	410	001	06	00	00	1					
14													
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18													

ENTERED
DEC 18 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Carnell

Supervisor's Signature Jim Bagley by Pam Stephens

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee KELLY DURBOROW

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 7 Year 0 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	257	021		01	00	058						
2	24	257	020		03	00	058						
3	24	256	020		04	00	058						
4	25	391	010		00	40	058						
5	25	256	020		02	20	058						
6	25	256	021		01	00	058						
7	25	257	020		04	00	058						
8	25	257	021		02	00	058						
9	26	256	020		04	00	058						
10	26	011	021		02	00	058						
11	27	257	020		02	00	058						
12	27	257	021		01	40	058						
13	27	256	020		04	00	058						
14	27	266	010		00	20	058						
15	28	257	010		01	20	058						
16	28	257	020		03	20	058						
17	28	256	020		03	20	058						
18													

ENTERED
OCT 25 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Kelly Durborow

Supervisor's Signature Jane Ann Nichols for

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	233	021		06	40							
2	05	385	021		03	20							
3	05	233	021		03	00							
4	05	287	021		01	00							
5	05	374	021		02	00							
6	06	301	003		08	00							
7	07	330	021		01	00							
8	07	377	021		01	00							
9	07	233	021		03	00							
10	07	385	021		01	00							
11	07	385	021		02	00							
12	08	289	021		04	00		AHW					
13	08	~~239~~ 289	021		01	00							
14	08	233	021		03	00				JAN 05 2000			
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	289	021		06	00							
2	11	287	021		02	00							
3	12	385	021		02	00							
4	12	233	021		03	00							
5	12	374	021		02	00							
6	12	330	021		01	40							
7	13	391	021		02	20							
8	13	349	021		01	00							
9	13	233	021		01	00							
10	13	385	021		01	00							
11	13	374	021		02	00							
12	14	289	021		03	00							
13	14	233	021		03	00							
14	14	374	021		02	00							
15	14	287	021		01	00							
16	15	289	021		01	00							
17	15	385	021		03	00							
18	15	233	021		01	00							

ENTERED
DEC 17 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Marks

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 6 of 6

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	021		01	00							
2	18	385	021		04	00							
3	18	233	021		03	00							
4	19	385	021		02	00							
5	19	287	021		03	00							
6	19	233	021		02	00							
7	19	391	021		01	00							
8	20	374	021		03	00							
9	20	287	021		03	00							
10	20	391	021		02	00							
11	20	385	021		00	40							
12	20	233	021		01	00							
13	21	385	021		08	00							
14	22	385	021		01	00							
15	22	391	021		03	00							
16	22	378	021		01	00							
17	22	289	021		03	00							
18													

ENTERED
JAN 19 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Maley

OK

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	021		01	00							
2	22	233	021		01	00							
3	22	374	021		02	00							
4	22	378	021		00	40							
5	22	349	021		00	40							
6	22	287	021		00	20							
7	22	289	021		00	20							
~~OK~~	~~22~~	~~301~~	~~003~~		~~02~~	~~00~~	OK						
9	23	301	021		08	00							
10	24	289	021		05	00							
11	24	374	021		02	00							
12	24	385	021		01	00							
13	25	301	009		08	00							
14	26	301	004		08	00							
15													
16													
17													
18													

ENTERED
JAN 31 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	002		02	20							
2	01	285	021		01	40							
3	01	385	021		01	20							
4	01	287	021		01	20							
5	01	374	021		01	20							
6	02	289	021		04	00							
7	02	285	021		01	00							
8	02	330	021		01	00							
9	02	385	021		01	00							
10	02	378	021		00	40							
11	02	391	021		00	20							
12	03	289	021		03	00							
13	03	374	021		02	00							
14	03	285	021		02	00							
15	03	287	021		01	00							
16													
17													
18													

ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page ~~Page 3 of 5~~ 3

Month 12 Year 99

Employee Sonja Joyce Fouquet

Social Security Number ~~Budget Ac~~ PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	289	021		03	00							
2	13	287	021		01	00							
3	13	330	021		01	00							
4	13	374	021		03	00							
5	13	285	021		01	00							
6	14	374	021		02	00							
7	14	289	021		~~03~~ 02	~~30~~ 00	38A						
8	14	288	021		02	00							
9	14	233	021		02	00							
10	15	385	021		03	00							
11	15	391	021		01	00							
12	15	377	021		01	00							
13	15	383	021		01	00							
14	15	374	021		02	00							
15	15	285	021		02	00							
16	16	378	021		01	00							
17	16	349	021		01	00							
18	16	383	021		01	00							

ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

7

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 6

Employee Sonja Joyce Fouquet

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12/6	3697	021		01	00							
2	12/6	3777	021		01	00							
3	12/6	3891	021		01	00							
4	12/6	2899	021		02	00							
5	12/6	3855	021		01	00							
6	~~12/6~~ 12/7	3855	021		04	00							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 7 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	289	021		02	20							
2	06	287	021		01	40							
3	06	374	021		02	00							
4	06	285	021		02	00							
5	06	330	021		01	00							
6	07	285	021		05	00							
7	07	374	021		01	00							
8	07	233	021		01	00							
9	07	383	021		01	00							
10	07	289	021		02	00							
11	08	285	021		05	00							
12	08	385	021		01	00							
13	08	287	021		01	00							
14	08	374	021		02	00							
15	09	285	021		01	00							
16	09	289	021		01	00							
17	09	377	021		01	00							
18	09	391	021		01	00							

ENTERED
MAR 13 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 1

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 275

Month 01 Year 00

Employee Sonja Joyce Fouquet

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	285	021		04	00							
2	10	369	021		02	00							
3	10	289	021		01	00							
4	10	374	021		02	00							
5	11	301	021		02	00							
6	11	385	021		04	00							
7	11	391	021		01	00							
8	11	378	021		01	00							
9	11	349	021		01	00							
10	12	385	021		06	00							
11	12	374	021		01	00							
12	12	391	021		01	00							
13	12	233	021		01	00							
14	13	301	003		09	00							
15	14	391	021		01	00							
16	14	377	021		01	00							
17	14	285	021		01	00							
18	14	287	021		01	00							

ENTERED
MAR 22 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Johnnie Myers

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	301	021		04	00							
2	24	287	021		02	00							
3	24	374	021		01	00							
4	24	349	021		01	00							
5	24	377	021		01	00							
6	25	379	021		01	20							
7	25	374	021		02	00							
8	25	287	021		01	20							
9	25	330	021		01	00							
10	25	289	021		01	20							
11	25	288	021		01	00							
12	25	301	021		01	00							
13	26	301	014		09	00							
14	27	301	014		09	00							
15	28	301	014		01	20							
16	28	301	DD3		02	40							
17													
18													

ENTERED
MAR 22 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	21	301	009		08	00							
2	22	301	021		02	00							
3	22	289	021		03	00							
4	23	284	021		03	00							
5	22	391	021		01	00							
6	23	284	021		01	00							
7	23	287	021		01	00							
8	23	385	021		01	00							
9	23	233	021		01	00							
10	23	291	021		02	00							
11	23	388	021		01	00							
12	23	374	021		02	00							
13	24	330	021		02	00							
14	24	289	021		02	00							
15	24	667	021		02	00							
16	24	378	021		02	00							
17	24	287	021		01	00							
18	25	289	021		05	00							

ENTERED
JUN 15 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	284	021		02	00							
2	01	374	021		01	00							
3	01	671	021		01	00							
4	01	289	021		01	00							
5	01	233	021		02	00							
6	01	385	021		02	00							
7	02	301	003		04	00							
8	03	391	021		01	00							
9	03	371	021		01	00							
10	03	383	021		01	00							
11	03	233	021		01	00							
12	03	289	021		01	00							
13	03	330	021		01	00							
14	03	287	021		01	00							
15	03	374	021		01	00							
16	03	284	021		01	00							
17													
18													

ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	301	003		08	00							
2	07	284	021		02	00							
3	07	287	021		03	00							
4	07	314	021		02	00							
5	08	383	021		01	00							
6	08	317	021		01	00							
7	08	391	021		01	00							
8	08	233	021		02	60							
9	08	385	021		02	00							
10	08	284	021		02	00							
11	09	301	003		07	00							
12	10	391	021		01	00							
13	10	349	021		01	00							
14	10	385	021		02	00							
15	10	314	021		03	00							
16	10	289	021		01	00							
17	10	667	021		01	00							
18													

ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	301	003		09	00							
2	14	301	002		01	00							
3	14	285	021		02	00							
4	14	314	021		02	40							
5	14	284	021		01	20							
6	15	314	021		01	00							
7	15	284	021		02	00							
8	15	287	021		01	00							
9	15	391	021		01	00							
10	15	383	021		01	00							
11	15	233	021		01	00							
12	15	289	021		01	00							
13	15	677	021		02	00							
14	16	377	021		02	00							
15	16	287	021		04	00							
16	16	377	021		01	00							
17	16	677	021		02	00							
18	17	383	021		02	40							

ENTERED
JUN 05 2000
TIME & EFFORT

Adjusted

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20391	021			02	00							
2	20383	021			04	00							
3	21385	021			05	00							
4	21330	021			01	00							
5	21383	021			02	20							
6	22385	021			03	00							
7	22330	021			01	00							
8	22383	021			03	20							
9	22284	021			01	00							
10	22289	021			01	00							
11	22374	021			01	00							
12	22667	021			01	00							
13	23301	003			05	40							
14	24374	021			04	00							
15	24289	021			04	00							
16	24284	021			02	00							
17													
18													

ENTERED
JUN 05 2000
TIME & EFFORT

adjusted Work Week

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	349	021		03	00							
2	27	284	021		01	00							
3	27	385	021		01	00							
4	27	289	021		01	00							
5	27	374	021		02	00							
6	27	287	021		01	00							
7	28	374	021		06	00							
8	28	288	021		01	00							
9	28	289	021		02	00							
10	29	289	021		03	00							
11	30	374	021		05	00							
12	30	384	021		01	00							
13	30	377	021		01	00							
14	30	287	021		01	00							
15	30	289	021		01	00							
16	31	374	021		05	00							
17	31	377	021		01	00							
18	31	391	021		01	00							

ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Mark

ODH Form 4

7

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	374	021		00	20							
2	17	385	021		01	00							
3	17	391	021		01	00							
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
JUN 05 2000
TIME & EFFORT

Adjusted Wk 1 week

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1 of 4

Month 04 Year 00

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	378	021		00	20							
2	10	388	021		00	20							
3	10	349	021		00	20							
4	10	383	021		00	20							
5	10	369	021		00	20							
6	10	377	021		00	20							
7	10	391	021		00	20							
8	10	284	021		01	00							
9	10	289	021		01	00							
10	10	385	021		02	00							
11	10	287	021		01	00							
12	10	374	021		01	40							
13	11	677	021		01	00							
14	11	289	021		03	00							
15	12	385	021		03	00							
16	12	388	021		01	00							
17	12	391	021		02	00							
18	12	374	021		01	00							

ENTERED
JUN 2 3 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2 of 4

Employee: Sonja Joyce Touquet

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month: 04 Year: 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	28	70	21	02	00							
2	13	37	40	21	01	00							
3	13	28	90	21	02	00							
4	13	28	70	21	02	00							
5	13	28	40	21	02	00							
6	13	39	10	21	00	20							
7	13	38	30	21	00	20							
8	13	37	80	21	00	20							
9	13	38	50	21	02	00							
10	14	28	40	21	02	00							
11	14	28	90	21	01	00							
12	14	28	70	21	01	00							
13	14	37	40	21	01	00							
14	14	38	50	21	01	00							
15	14	39	10	21	01	00							
16	14	38	30	21	01	00							
17	14	36	90	21	01	00							
18	14	37	90	21	01	00							

ENTERED
JUN 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature: Sonja Joyce Touquet

Supervisor's Signature: Gregory A Mosley

dm

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

1

Page 3 of 4

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	374	021		03	00							
2	18	289	021		02	00							
3	18	330	021		03	00							
4	18	287	021		01	00							
5	18	233	021		01	00							
6	19	289	021		03	00							
7	19	385	021		01	00							
8	19	284	021		01	00							
9	19	287	021		02	00							
10	19	330	021		02	00							
11	19	391	021		01	00							
12	20	317	021		02	00							
13	20	289	021		04	00							
14	20	284	021		02	00							
15	20	317	021		01	00							
16	20	301	002		01	00							
17	21	385	022		01	00							
18	21	317	021		01	00							

ENTERED
JUN 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	284	021		02	00							
2	24	287	021		03	00							
3	24	385	021		02	00							
4	24	391	021		01	00							
5	24	377	021		01	00							
6	25	377	021		01	00							
7	25	284	021		01	06							
8	25	289	021		01	06							
9	25	287	021		02	00							
10	25	374	021		02	00							
11	25	330	021		03	00							
12	26	289	021		02	40							
13	26	287	021		01	00							
14	26	374	021		02	00							
15	26	391	021		01	20							
16	26	330	021		02	00							
17	27	289	021		09	00							
18	28	288	021		04	00							

ENTERED
JUN 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Peggy A Morley

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4 of 4

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	349	021		01	00							
2	21	383	021		01	00							
3	21	369	021		01	00							
4	21	391	021		01	00							
5	21	287	021		01	00							
6	21	374	021		03	00							
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													

RECEIVED
JUN 29 2000

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5 of 4

Employee Sonja Joyce Fauquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	284	021		02	00							
2	24	289	021		03	00							
3	24	385	021		02	00							
4	24	391	021		01	00							
5	24	377	021		01	00							
6	25	377	021		01	00							
7	25	284	021		01	00							
8	25	289	021		01	00							
9	25	287	021		02	00							
10	25	374	021		02	00							
11	25	330	021		02	00							
12	26	289	021		02	40							
13	26	287	021		01	00							
14	26	374	021		02	00							
15	26	391	021		01	20							
16	26	330	021		02	00							
17	27	289	021		09	00							
18	28	288	021		04	00							

JUL 14 2000

TIME

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

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Page ~~1~~ 1

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	677	021		01	00							
2	03	391	021		02	00							
3	03	377	021		01	00							
4	03	374	021		02	00							
5	03	289	021		01	00							
6	03	287	021		02	00							
7	04	289	021		03	00							
8	04	374	021		02	00							
9	05	330	021		02	00							
10	05	391	021		01	00							
11	05	289	021		03	00							
12	05	285	021		02	00							
13	05	287	021		02	00							
14	06	385	021		02	00							
15	06	391	021		01	00							
16	06	284	021		02	00							
17	06	677	021		01	00							
18	06	289	021		02	00							

RECEIVED
JUL 05 2000

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1 of 2

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	301	003		08	00							
2	02	314	021		03	00							
3	02	330	021		01	00							
4	02	287	021		02	00							
5	02	289	021		01	00							
6	02	378	021		01	00							
7	02	388	02		01	00							
8	03	377	021		01	00							
9	03	391	021		01	00							
10	03	349	021		01	00							
11	03	233	021		01	00							
12	03	284	021		03	00							
13	03	287	021		01	20							
14	03	314	021		01	40							
15	04	374	021		04	00							
16	04	385	021		01	00							
17	04	391	021		01	00							
18	04	378	021		01	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Works

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 06

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	301	003		09	00	[illegible]						
2	09	289	021		03	40							
3	09	385	021		02	00							
4	09	233	021		01	00							
5	09	391	021		01	00					ENTERED		
6	09	374	021		00	20							
7	09	284	021		01	00							
8	10	301	021		08	00							
9	10	301	002		01	00							
10	11	289	021		04	00							
11	11	374	021		02	00							
12	11	391	021		01	00							
13	11	385	021		02	00							
14	12	374	021		02	00							
15	12	385	021		02	00							
16													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 48 of 57

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	374	021		02	20							
2	15	385	021		02	00							
3	15	383	021		01	00							
4	15	349	021		01	00							
5	16	374	021		01	40					ENTERED		
6	16	385	021		01	20							
7	16	391	021		01	00							
8	16	677	021		01	00							
9	16	330	021		04	00							
10	17	330	021		03	00							
11	17	377	021		04	00							
12	17	385	021		02	00							
13	18	374	021		00	40							
14	18	374	021		04	40							
15	18	391	021		02	00							
16	18	378	021		01	00							
17	18	289	021		01	00							
18	18	287	021		01	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Peggy A Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3 of 5 (7)

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 06

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	289	021		01	00							
2	19	391	021		01	20							
3	19	374	021		02	00							
4	19	388	021		01	00							
5													
6													
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ENTERED

T... EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 6 of 8

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	3C1	002		04	20							
2	23	289	021		03	00							
3	23	385	021		03	00							
4	23	374	021		03	00							
5	24	284	021		03	00							
6	24	283	021		01	00							
7	24	391	021		02	00							
8	24	383	021		01	00							
9	24	388	021		01	00							
10	24	330	021		01	00							
11	24	374	021		01	00							
12	25	349	021		02	00							
13	25	377	021		02	00							
14	25	383	021		01	06							
15	25	378	021		01	00							
16	25	287	021		01	00							
17	25	385	021		01	00							
18	25	289	021		01	00							

ENTERED
[illegible] 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature [illegible]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	378	021		02	00							
2	19	349	021		02	00							
3	19	391	021		04	00							
4	19	369	021		02	00							
5	20	385	021		04	00							
6	20	388	021		01	00							
7	20	383	021		01	00							
8	20	289	021		04	00							
9	20	330	021		02	00							
10	20	285	021		03	00							
11	21	374	021		03	00							
12	21	287	021		03	00							
13	21	288	021		02	00							
14	21	377	021		02	00							
15	21	233	021		02	00							
16	22	374	021		04	00							
17	22	289	021		01	00							
18	22	377	021		02	00							

ENTERED
SEP 7 1 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Marley MS

ODH Form 4

Page 1

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 7 & ~~8 of 8~~

Employee Sonja Joyce Fouquet

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	285	021		01	00							
2	25	233	021		01	20							
3	25	314	021		01	00							
4	25	287	021		01	00							
5	25	391	021		01	00							
6	25	317	021		01	00							
7	25	383	021		01	00							
8	26	284	021		03	00							
9	26	385	021		02	00							
10	26	330	021		01	00				SEP 08			
11	26	233	021		01	00							
12	26	314	021		01	00							
13	26	289	021		02	00							
14	26	249	021		02	00							
15	27	274	021		02	40							
16	27	349	021		01	00							
17	27	383	021		01	00							
18	27	284	021		02	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Cimarusti MS

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2 of 5

Employee Sonja Joyce Fouquet

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	374	021		03	00				ENTERED			
2	10	677	021		01	00				OCT 25 2000			
3	10	377	021		01	00				TIME & EFFORT			
4	10	383	021		01	00							
5	11	301	003		07	20							
6	12	374	021		02	00							
7	12	384	021		01	00							
8	12	385	021		01	00							
9	12	378	021		01	00							
10	12	391	021		01	00							
11	12	369	021		01	00							
12	12	349	021		01	00							
13	13	374	021		01	00							
14	13	287	021		01	00							
15	13	289	021		02	00							
16	13	330	021		01	00							
17	13	385	021		01	00							
18	13	388	021		01	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja F 7/10/00

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	301	003		05	40				ENTERED			
2	18	314	021		05	00				OCT 25 2000			
3	19	233	021		02	00				TIME & EFFORT			
4	19	391	021		02	00							
5	19	369	021		03	00							
6	19	383	021		02	00							
7	20	289	021		05	00							
8	20	314	021		05	00							
9	21	233	021		01	00							
10	21	388	021		00	40							
11	21	377	021		00	40							
12	21	671	021		02	00							
13	21	289	021		02	00							
14	21	330	021		02	00							
15	21	287	021		02	00							
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	24	233	021		01	00				ENTERED			
2	24	284	021		01	00				OCT 25 2000			
3	24	377	021		01	40				TIME & EFFORT			
4	24	383	021		01	20							
5	24	374	021		01	00							
6	24	287	021		01	00							
7	24	289	021		01	40							
8	24	391	021		01	00							
9	25	289	021		01	00							
10	25	374	021		02	00							
11	25	349	021		02	00							
12	25	385	021		04	00							
13	26	385	021		03	20							
14	26	349	021		03	40							
15	26	377	021		01	00							
16	26	289	021		01	00							
17	27	374	021		09	00							
18	27	374	021		03	20							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Sonja Joyce Faquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	374	021		02	00							
2	14	385	021		02	00							
3	14	391	021		01	00							
4	14	377	021		01	00							
5	14	289	021		02	00							
6	15	287	021		04	00							
7	15	285	021		02	00							
8	15	259	021		02	00							
9	16	284	021		02	00							
10	16	287	021		02	00							
11	16	374	021		03	00							
12	16	289	021		01	00							
13	17	369	021		01	00							
14	17	330	021		02	00							
15	17	289	021		02	00							
16	17	287	021		01	00							
17	17	374	021		02	00							
18	18	374	021		03	00							

ENTERED
NOV 0 8 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Faquet

Supervisor's Signature Gregory A Morley

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

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Page 4 of 5

Employee Sonja Joyce Fouquet

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	289	021		00	40							
2	07	284	021		00	20							
3	07	330	021		00	40							
4	07	374	021		00	40							
5	07	285	021		00	40							
6	07	287	021		00	40							
7	07	378	021		00	20							
8	07	349	021		00	40							
9	07	383	021		00	40							
10	08	284	021		04	00							
11	08	374	021		02	00							
12	08	349	021		01	00							
13	08	284	021		01	00							
14	09	391	021		04	00							
15	09	374	021		02	00							
16	09	289	021		02	00							
17	10	374	021		03	00							
18	10	284	021		02	00							

ENTERED
NOV 11 0 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2 of 5

Employee Sonja Joyce Fouquet

Social Security Number — PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	10	677	021		01	00							
2	10	391	021		02	00							
3	11	284	021		03	20							
4	11	289	021		01	00							
5	11	374	021		02	00							
6	11	301	0002		01	40							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
NOV 09 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A. Morley

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 6

Employee [illegible]

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	374	021		02	00							
2	14	385	021		02	00							
3	14	291	021		01	00							
4	14	377	021		01	00							
5	14	289	021		02	00							
6	15	287	021		04	00							
7	15	284	021		02	00							
8	15	289	021		02	00							
9	16	284	021		02	00							
10	16	287	021		02	00							
11	16	374	021		02	00							
12	16	289	021		01	00							
13	17	269	021		01	00							
14	17	330	021		02	00							
15	17	289	021		02	00							
16	17	287	021		01	00							
17	17	314	021		02	00							
18	18	374	021		02	00							

ENTERED
NOV 17 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [illegible]

Supervisor's Signature [illegible]

ODH Form 4

1 of 2

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 5

Employee Sonja Joyce Fouquet

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	18	301	002		01	20							
2	18	289	021		08	00							
3	18	383	021		01	00							
4	18	287	021		01	40							
5	19	301	021		01	00							
6	19	233	021		01	00							
7	19	289	021		01	00							
8	19	284	021		04	00							
9	19	391	021		01	00							
10	20	284	021		01	00							
11	20	617	021		01	00							
12	20	385	021		01	00							
13	26	378	021		02	00							
14	20	347	021		01	00							
15	20	289	021		08	00							
16	21	233	021		02	00							
17	21	284	021		02	00							
18	21	385	021		04	00							

ENTERED
NOV 28 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

~~1 of 1~~ Page 1 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	301	002		00	40							
2	25	391	021		01	20							
3	25	257	021		01	00							
4	25	388	021		01	00							
5	25	383	021		01	00							
6	25	289	021		03	00							
7	26	289	021		03	00							
8	26	385	021		02	00							
9	26	391	021		01	40							
10	26	287	021		00	40							
11	26	378	021		00	40							
12	27	677	021		01	00				ENTERED			
13	27	289	021		04	00				NOV 29 2000			
14	27	330	021		01	00				TIME & EFFORT			
15	27	233	021		01	00							
16	27	391	021		01	00							
17	28	287	021		03	00							
18	28	289	021		03	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Regory A Morley

ODH Form 4

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Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page Page 6

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	385	021		02	00							
2	29	391	021		02	00							
3	29	349	021		01	00							
4	29	289	021		05	00							
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
NOV 28
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Trudy L Frost

Month: 10 Year: 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	231	021		07	20	018						
2	04	231	010		00	40	018						
3	05	240	020		02	40	018						
4	05	240	010		00	20	018						
5	05	231	010		01	00	058						
6	05	318	021		02	00	058						
7	05	231	021		02	00	058						
8	06	240	010		00	40	018						
9	06	240	020		05	00	018						
10	06	231	021		02	20	018						
11	07	391	010		02	20	058						
12	07	391	021		05	40	058						
13	08	231	021		06	00	018						
14	08	231	020		02	00	018						
15													
16													
17													
18													

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JAN 10 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

ODH Form 4

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Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	231	020		03	40	058						
2	01	231	010		01	20	058						
3	01	391	020		01	00	058						
4	01	266	020		02	00	058						
5	02	231	020		05	00	058						
6	02	231	021		01	00	018						
7	02	266	020		02	00	018						
8	03	231	020		04	00	018						
9	03	231	021		01	00	018						
10	03	266	020		03	00	018						
11	04	231	010		03	00	018						
12	04	231	021		05	00	018						
13	05	231	010		03	00	018						
14	05	231	021		05	00	018						
15													
16													
17													
18													

[redacted] FEB 04 2000 [redacted]

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost AEP

Supervisor's Signature Jane Ann Nichols AEP

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	231	010		02	00	058						
2	08	231	020		05	00	058						
3	08	391	020		01	00	018						
4	09	231	020		01	00	018						
5	09	231	021		01	00	018						
6	09	266	020		02	00	018						
7	09	318	010		01	20	058						
8	09	318	021		02	40	058						
9	10	391	010		01	20	058						
10	10	391	021		02	40	058						
11	10	231	020		03	00	018						
12	10	266	020		01	00	018						
13	11	301	009		08	00	018						
14	12	231	010		02	00	058						
15	12	266	020		03	00	058						
16	12	231	021		02	00	058						
17	[redacted]	391	021		01	00	058						
18													

FEB 04 2000

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee TRUDY L. FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	231	010		02	00	058						
2	15	231	020		01	20	058						
3	15	391	020		01	40	058						
4	15	391	021		02	00	058						
5	15	231	021		01	00	058						
6	16	266	020		02	00	018						
7	16	231	020		02	00	018						
8	16	231	021		01	00	018				ENTERED		
9	16	318	021		03	00	018				DEC 28 1999		
10	17	231	021		02	00	018				TIME & EFFORT		
11	17	391	021		02	00	018						
12	17	318	021		02	00	018						
13	17	266	020		02	00	018						
14	18	231	010		01	20	058						
15	18	231	020		05	40	058						
16	18	391	021		01	00	058						
17	19	231	010		01	20	058						
18	19	231	021		06	40	058						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	231	010		01	20	058						
2	22	231	020		04	00	058						
3	22	231	021		01	40	058						
4	22	391	020		01	00	058						
5	23	318	021		05	00	018						
6	23	231	020		02	00	018						
7	23	266	020		01	00	018						
8	24	231	020		02	00	018						
9	24	231	021		02	00	018						
10	24	266	020		02	00	018						
11	24	318	020		02	00	018						
12	25	301	009		08	00	018						
13	26	301	009		08	00	018						
14													
15													
16													
17													
18													

ENTERED
DEC 9 8 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Jane Ann Nichols

8

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Trudy L. Frost

Month 11 Year 99

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	231	010		02	20	058						
2	29	391	020		04	00	058						
3	29	391	021		00	40	058						
4	29	231	020		01	00	058						
5	30	231	021		02	00	018						
6	30	313	021		05	00	018						
7	30	266	020		01	00	018						
8													
9													
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11													
12													
13													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature JoAnn Nicholson

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	231	010		01	20	058						
2	27	231	020		02	40	058						
3	27	266	020		02	00	058						
4	27	391	020		02	00	058						
5	28	266	020		04	00	018						
6	28	231	020		04	00	018						
7	29	231	021		03	00	018						
8	29	266	020		02	40	018						
9	29	301	003		02	20	018						
10	30	301	002		08	00	018						
11	31	301	009		08	00	018						
12													
13													
14													
15													
16													
17													
18													

ENTERED
FEB 25 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Jane Ann Nichols MD

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Trudy Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	301	002		08	00	058						
2	21	231	020		03	00	058						
3	21	231	021		01	00	058						
4	21	266	020		01	00	018						
5	21	318	021		03	00	018						
6	22	231	020		04	00	018						
7	22	231	021		02	00	018						
8	22	266	020		02	00	018						
9	23	231	010		02	00	058						
10	23	231	020		01	20	058						
11	23	231	021		02	40	058						
12	23	391	020		02	00	058						
13	24	301	009		08	00	018						
14													
15													
16													
17													
18													

ENTERED
FEB 11 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols PhD

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	231	010		02	00	058						
2	13	231	020		02	40	058						
3	13	266	020		02	20	058						
4	13	391	020		01	00	058						
5	14	318	021		04	00	018						
6	14	266	020		01	00	018						
7	14	231	020		03	00	018						
8	15	391	021		05	40	058	1					
9	15	391	010		02	20	058	1					
10	16	391	021		05	40	058	1					
11	16	391	010		02	20	058	1					
12	17	301	002		05	00	018						
13	17	231	021		03	00	018						
14													
15													
16													
17													
18													

ENTERED FEB 11 2000 TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Trudy L Frost

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	231	010		0120		058						
2	06	231	020		0300		058						
3	06	391	020		0200		058						
4	06	266	020		0140		058						
5	07	266	020		0300		018						
6	07	231	020		0300		018						
7	07	231	021		0100		018						
8	07	266	021		0100		018						
9	08	391	010		0220		058						
10	08	391	020		0300		068						
11	08	391	021		0240		058						
12	09	231	010		0120		058						
13	09	231	020		0240		058						
14	09	231	021		0100		058						
15	09	266	020		0200		058						
16	10	231	010		0300		018						
17	10	231	021		0500		016						
18													

ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols PhD

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	231	020		05	00	018						
2	01	231	021		01	00	018						
3	01	266	020		02	00	018						
4	02	231	020		03	00	058						
5	02	266	020		02	00	058						
6	02	231	010		02	00	058						
7	03	391	020		01	00	058	1					
8	03	231	010		01	20	058						
9	03	231	020		02	00	058						
10	03	231	021		01	40	058						
11	03	391	020		01	20	058	1					
12	03	266	020		01	40	058						
13													
14													
15										ENTERED			
16										FEB 29 2000			
17										TIME & EFFORT			
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nicholson

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee TRUDY L. FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 1 Year 0 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	10	318	010		01	200	058						
2	10	318	021		03	000	058						
3	10	231	020		02	400	018						
4	10	231	021		01	000	018						
5	11	266	020		03	000	018						
6	11	231	020		01	400	018						
7	11	231	021		01	200	018						
8	11	318	021		02	000	018						
9	12	231	020		03	000	018						
10	12	231	021		03	000	018						
11	12	266	020		02	000	018						
12	13	231	010		02	000	058						
13	13	231	020		02	000	058						
14	13	391	020		02	000	058	1					
15	13	391	021		02	000	058	1					
16	14	231	010		02	000	058						
17	14	231	021		04	000	058						
18	14	391	021		02	000	058	1					

ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols/25

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee TRACY FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	301	009		08	00	013						
2	18	311	021		05	00	017						
3	18	231	020		02	00	018						
4	18	231	021		01	00	018						
5	19	231	020		02	00	018						
6	19	266	020		02	00	018						
7	19	251	021		04	00	018						
8	20	231	010		01	20	058						
9	20	231	021		04	00	058						
10	20	231	020		02	40	058						
11	21	391	020		01	00	058						
12	21	391	021		02	00	058						
13	21	231	010		01	20	058						
14	21	231	020		02	40	058						
15	21	266	020		01	00	058						
16													
17													
18													

ENTERED
FEB 2 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tracy L Frost

Supervisor's Signature Jane Ann Nichols 2/25

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Judy L. Frost

Month 01 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	31	231	010		01	20	058						
2	31	231	020		01	40	058						
3	31	231	021		01	00	058						
4	31	266	020		02	00	058						
5	31	391	020		02	00	058	1					
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7													
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12													
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16													
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ENTERED
MAR 31 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Judy L Frost

Supervisor's Signature Jane Ann Nichols /JS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		0020	018	'						
2	01	318	010		0200	018							
3	01	318	021		0300	018							
4	01	231	020		0140	018							
5	01	231	021		0100	018							
6	02	301	003		0800	018							
7	03	391	020		0200	058	'						
8	03	391	010		0200	058	'						
9	03	231	020		0200	058							
10	03	266	020		0200	058							
11	04	391	010		0120	058	'						
12	04	391	021		0640	058	'						
13													
14													
15													
16													
17													
18													

ENTERED
JUN 15 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature JaneAnn Nichols 6/23

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee TRUDY L FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	231	010		012	00	058						
2	14	231	020		024	00	058						
3	14	391	021		010	00	058						
4	14	391	020		010	00	058						
5	14	231	021		020	00	058						
6	15	318	021		050	00	018						
7	15	231	020		020	00	018						
8	15	231	021		010	00	018						
9	16	240	021		060	00	018						
10	16	257	020		020	00	018						
11	17	240	010		060	00	018						
12	17	240	021		020	00	018						
13	18	240	010		060	00	018						
14	18	240	021		020	00	018						
15													
16													
17													
18													

ENTERED
MAY 24 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature JoAnn Nichols/05

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Trudy Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	301	009		08	00	018						
2	22	318	021		04	00	018						
3	22	391	020		02	40	058						
4	22	391	010		01	20	058						
5	23	231	020		04	00	018						
6	23	240	021		01	00	018						
7	23	240	010		00	20	018						
8	23	240	020		02	40	018						
9	24	231	010		01	20	068						
10	24	231	020		05	40	068						
11	24	231	021		01	00	058						
12	25	231	010		01	20	058						
13	25	231	021		03	20	058						
14	25	391	021		03	20	058						
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Jane Ann Nichols 1/28

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	28	231	010		02	00	058						
2	28	231	020		04	00	058						
3	28	266	020		01	00	058						
4	28	231	021		01	00	058						
5	29	318	021		04	00	018						
6	29	291	020		03	00	018						
7	29	291	021		01	00	018						
8													
9													
10													
11													
12													
13													
14													
15													
16										ENTERED			
17										MAY 24 2000			
18										TIME & EFFORT			

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Judy L Frost

Supervisor's Signature Jane Ann Nichols 125

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee TRUDY L FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		04	00	058						
2	[redacted]	391	010		02	00	058	1					
3	01	391	021		01	00	058	1					
4	01	231	021		01	00	018						
5	02	231	010		01	20	058						
6	02	231	020		02	40	058						
7	02	231	021		03	00	058						
8	02	266	020		01	00	058						
9	03	391	010		01	20	058	1					
10	03	391	021		06	40	058	1					
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols 1/25

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee TRUDY L. FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 3 Year 0 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	010		03	20	058						
2	06	391	021		04	40	058						
3	07	318	010		02	00	066						
4	07	318	021		03	20	066						
5	07	231	020		02	40	066						
6	08	231	021		02	40	018						
7	08	231	020		03	20	018						
8	08	266	020		02	00	018						
9	09	231	010		01	20	058						
10	09	231	020		04	40	058						
11	09	231	021		02	00	058						
12	10	231	010		02	00	058						
13	10	231	020		03	20	058						
14	10	391	021		02	40	058						
15													
16													
17													
18													

ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols/ss

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee TRUDY FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	240	021		08	00	018						
2	14	240	021		08	00	018						
3	15	231	021		02	40	018						
4	15	231	010		01	20	018						
5	15	231	020		02	00	018						
6	15	266	020		02	00	018						
7	16	231	010		01	20	058						
8	16	231	021		06	40	058						
9	17	231	010		01	20	058						
10	17	231	021		01	00	058						
11	17	391	021		01	40	058						
12	17	318	021		04	00	058						
13													
14													
15													
16													
17													
18													

ENTERED
JUN 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols/JS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 6

Employee Trudy Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	231	010		012	00	58						
2	27	231	020		020	00	58						
3	27	266	020		020	00	58						
4	27	391	020		024	00	58						
5	28	318	021		040	00	18						
6	28	231	020		030	00	18						
7	28	231	021		030	00	18						
8	28	266	020		020	00	18			ENTERED			
9	29	231	021		020	00	18			JUN 28 2000			
10	29	240	010		010	00	18			TIME & EFFORT			
11	29	240	020		030	00	18						
12	30	231	010		012	00	58						
13	30	231	021		064	00	58						
14	31	231	010		012	00	58						
15	31	231	021		064	00	58						
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Jane Ann Nichols/JS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	231	010		01	20	058						
2	03	231	021		01	00	058						
3	03	241	020		02	20	058						
4	03	266	020		03	20	058						
5	04	301	009		08	00	018			ENTERED			
6	05	318	021		04	00	018			OCT 25 2000			
7	05	231	020		01	20	018			TIME & EFFORT			
8	05	266	020		02	40	018						
9	06	231	010		02	40	018						
10	06	231	021		05	20	018						
11	07	231	010		01	20	058						
12	07	231	021		04	40	058						
13	07	391	021		02	00	058						
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Jane Ann Nichols PhD

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee TRUDY L FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	318	010		01	40	066						
2	01	318	021		02	40	066						
3	01	231	010		01	20	058						
4	01	231	021		03	20	058						
5	02	231	021		03	00	018						
6	02	231	020		03	00	018						
7	02	266	020		02	00	018						
8	03	231	010		03	00	018						
9	03	231	021		05	00	018						
10	04	231	010		02	20	058						
11	04	231	021		04	00	058						
12	04	391	020		01	40	658						
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18													

ENTERED
OCT 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Trudy L. Frost ARNP

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	301	008		08	00	018						
2	08	266	010		01	40	058						
3	08	266	020		06	20	058						
4	08	391	020		01	00	058	1					
5	09	266	010		01	20	058						
6	09	266	020		06	40	058						
7	09	391	020		01	00	058	1					
8	10	266	010		01	20	058						
9	10	266	020		06	40	058						
10	10	391	020		01	00	058	1					
11	11	301	008		08	00	058						
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18													

ENTERED
NOV 0 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost ARNP

Supervisor's Signature Kelli Za

ODH Form 4

Amended

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 8 Year 0 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1													
2													
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11	11	301	0008		05	00	058						
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17													
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ENTERED
OCT 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost, ARNP

Supervisor's Signature Kelli M. Za

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	231	010		02	00	058						
2	14	391	020		03	00	058						
3	14	266	020		09	00	058						
4	15	318	021		03	00	018						
5	15	266	010		01	40	058						
6	15	266	020		05	20	058						
7	16	231	021		04	00	018			ENTERED NOV 03 2000 TIME & EFFORT			
8	16	231	020		01	00	018						
9	16	266	020		03	00	018						
10	18	231	021		02	00	018						
11	18	275	010		01	20	018						
12	18	275	021		04	40	018						
13													
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16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Kelli Fox

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Amended

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	231	010		012	058							
2	28	231	020		060	058							
3	28	266	020		014	058							
4	28	340	020		010	058							
5	29	318	010		020	018							
6	29	318	021		060	018							
7	30	231	021		074	018							
8	30	231	010		002	018							
9	31	231	010		012	058							
10	31	231	020		010	058							
11	31	266	020		044	058							
12	31	391	021		020	058							
13	31	340	020		010	058							
14													
15													
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17													
18													

ENTERED
OCT 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Peggy Hasheminour

Month 09 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	233	021		00	20	058						
2	05	240	021		00	20	058						
3	05	374	021		04	20	058						
4	06	391	021		00	40	058						
5	06	257	021		02	20	058						
6	06	374	021		00	40	058						
7	06	234	021		00	20	058						
8	06	238	021		03	00	058						
9	07	238	021		06	00	058						
10	07	234	021		00	40	058						
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ENTERED
NOV 2 8 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy Hasheminour

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Peggy Hashemipour

Month 09 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	374	021		07	40	058						
2	18	231	021		00	20	058						
3	18	238	021		01	00	058						
4	19	231	021		01	00	058						
5	19	374	021		03	00	058			ENTERED			
6	20	391	021		00	40	058			NOV 29 2000			
7	20	374	021		00	40	058			TIME & EFFORT			
8	20	288	021		00	20	058						
9	20	275	021		00	40	058						
10	20	233	021		00	20	058						
11	20	241	021		00	20	058						
12	20	250	021		00	40	058						
13	20	284	021		00	20	058						
14	21	257	021		02	00	058						
15	21	234	021		02	00	058						
16	21	374	021		02	00	058						
17	22	374	021		03	00	058						
18	22	257	021		03	00	058						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy Hashemipour

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hawkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	020		08	00	058						
2													
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9													
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ENTERED
SEP 28 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hawkins

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Amended

Page 4

Employee Tonya Hoskins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1													
2													
3													
4													
5	26	391	021		02	00	058						
6													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hoskins

Supervisor's Signature Jane Ann Nichols NLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		08	00	058						
2	25	391	020		08	00	058						
3	26	391	010		01	00	058						
4	26	391	020		05	00	058						
5	26	301	008		02	00	058	AMENDED					
6	27	391	010		00	20	058						
7	27	391	020		09	00	058						
8	28	391	010		00	20	058						
9	28	391	010		08	20	058						
10	29	391	020		06	00	058						
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12													
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ENTERED
SEP 28 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	[redacted]	30	1020		08	00	058						
2													
3													
4													
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6													
7													
8													
9													
10													
11													
12													
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ENTERED
SEP 28 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Month 08 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		0020	058							
2	01	391	020		0800	058							
3	02	391	020		0800	058							
4	03	391	010		0020	058							
5	03	391	020		0900	058					ENTERED		
6	04	391	021		0600	058					NOV 09 2000		
7	04	391	020		0200	058					TIME & EFFORT		
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	010		00	20	058						
2	07	391	020		06	40	058						
3	07	391	021		01	00	058						
4	08	391	020		08	00	058						
5	08	391	010		00	20	058						
6	09	391	010		00	20	058						
7	09	391	020		09	00	058						
8	10	391	010		00	20	058						
9	10	391	020		08	40	058						
10	11	391	010		00	20	058						
11	11	391	020		09	00	058						
12	12	391	010		00	20	058						
13	12	391	020		08	00	058						
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15													
16													
17													
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ENTERED
NOV 0 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

OOH Form 4

[redacted]

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Social Security Number : PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1													
2													
3													
4													
5	16	391	010		00	40	058						
6	16	391	020		05	00	058						
7	16	301	008		02	20	058						
8	17	301	008		08	00	058						
9	18	391	021		06	40	058						
10	18	301	008		01	20	058						
11													
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16													
17													
18													

ENTERED
OCT 23 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 03

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	010		00	40	058						
2	14	391	020		11	00	058						
3	15	391	020		06	00	058						
4	15	301	008		02	00	058						
5	16	391	010		00	40	058	AMENDED					
6	16	391	020		05	00	058						
7	17	301	008		08	00	058				ENTERED		
8	18	391	021		06	40	058				NOV 09 2000		
9	18	301	008		01	20	058				TIME & EFFORT		
10													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Month 08 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	020		08	00	058						
2	22	391	020		07	20	058						
3	22	391	010		00	40	058						
4	23	391	020		09	20	058						
5	23	391	010		00	20	058						
6	24	391	020		08	00	058						
7	25	391	020		11	00	058			ENTERED			
8	25	391	010		00	20	058			NOV 1 6 2000			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R. Hopkins

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	391	020		08	00	058						
2	29	391	020		08	00	058						
3	30	391	020		08	00	058						
4	31	391	020		08	00	058						
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ENTERED
NOV 0 - 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Social Security Number — PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		05	20	058						
2	01	301	008		02	40	058						
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ENTERED
NOV - 8 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number — PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	301	009		08	00	058						
2	05	391	020		08	00	058						
3	06	391	020		08	00	058						
4	07	391	020		08	00	058						
5	08	391	020		08	00	058						
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ENTERED
NOV 2 8 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Jennie Lim

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Month 09 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	020		08	20	058	1					
2	11	391	021		01	20	058	1					
3	12	391	020		09	00	058	1					
4	13	391	020		07	00	058	1					
5	13	301	008		01	00	058						
6	14	301	008		05	00	058						
7	14	301	003		03	00	058						
8	15	391	020		08	00	058						
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ENTERED
DEC 19 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	39 1	020		08	00	058						
2	19	39 1	010		00	20	058						
3	19	39 1	021		01	40	058						
4	19	39 1	020		07	00	058						
5	20	39 1	020		08	00	058						
6	21	39 1	020		08	00	058						
7	22	30 1	021		05	40	058						
8	22	30 1	010		01	20	058						
9	22	39 1	020		01	00	058						
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DEC 07 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	391	020		08	00	058						
2	26	391	020		08	00	058						
3	27	391	020		08	00	058						
4	28	391	020		08	00	058						
5	29	391	020		08	00	058						
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ENTERED
NOV 2 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Jane Ann Nichols

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	301	003		03	20	058						
2	06	301	010		01	20	018						
3	06	301	001		03	20	018						
4	07	301	001		06	00	058						
5	07	391	001		02	00	058						
6	08	301	002		08	00	058						
7	09	301	002		08	00	058						
8	10	301	002		08	00	058						
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ENTERED
MAR 0 1 2000
TIME & EFFORT

RECEIVED
DEC 27 1999
LOCAL HEALTH SERVICES

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

Supervisor's Signature Gayle Carpenter

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	301	010		01	40	018						
2	27	301	001		06	20	018						
3	28	391	010		02	00	058						
4	28	391	001		06	00	058						
5	29	391	010		02	00	058						
6	29	391	001		06	00	058						
7	30	301	010		08	00	058						
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ENTERED
FEB 29 2000
TIME & EFFORT

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LOCAL HEALTH SERVICES

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Jane Nichols

Supervisor's Signature CMB [redacted] Gayle Carper

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee J. Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	001		08	00	058						
2	11	301	010		01	20	018						
3	11	301	001		06	40	018						
4	12	301	001		08	00	058						
5	13	301	004		01	40	058						
6	13	301	001		06	20	058						
7	14	301	001		08	00	058						
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TIME & EFFORT

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LOCAL HEALTH SERVICES

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J. Nichols Supervisor's Signature Doyle Carr

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee J. Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	3011	001		08	40	058						
2	15	3911	001		12	00	058						
3	15	3911	010		00	40	058						
4	16	3011	010		01	40	018						
5	16	3011	001		06	20	018						
6	17	3011	608		02	00	058						
7	17	3011	001		05	00	018						
8	17	3011	010		01	00	018						
9	18	3011	010		03	20	018						
10	18	3011	001		05	40	058						
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NOV 13 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work [illegible]

RECEIVED
OCT 13 2000
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee J. Nichols

Month 08 Year 00

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	301	010		01	20	018						
2	21	301	001		06	40	018						
3	22	301	001		08	00	058						
4	23	301	001		01	20	018						
5	23	301	010		06	40	018						
6	24	301	001		08	00	058						
7	25	301	008		03	00	058						
8	25	301	001		05	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED
OCT 13 2000
LOCAL HEALTH SERVICES

Employee's Signature J Nichols

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	266	020		05	00	058						
2	25	241	020		02	00	058						
3	25	275	020		01	00	058						
4	26	238	020		01	00	058						
5	26	238	010		00	20	058						
6	26	266	020		02	00	058						
7	26	391	020		04	40	058						
8	27	391	020		08	00	058						
9	28	266	020		03	00	058						
10	28	275	020		00	40	058						
11	28	252	020		01	20	058						
12	28	241	020		03	00	058						
13	29	264	020		02	00	058						
14	29	391	020		06	00	058						
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ENTERED
JAN 06 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols RN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number ~~PERSONAL IDENTIFIER(S) REDACTED~~

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	266	020		04	00	058						
2	11	241	020		02	00	058						
3	11	391	020		01	00	058						
4	11	270	020		01	00	058						
5	12	391	020		08	00	058						
6	13	391	020		03	00	058						
7	13	340	020		02	00	058						
8	13	241	020		03	00	058						
9	14	241	021		08	00	058						
10	15	270	021		02	00	058						
11	15	231	021		03	00	058						
12	15	241	021		02	00	058						
13	15	241	010		01	00	058						
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ENTERED
DEC 7 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature JaneAnn Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 89

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	266	020		04	00	058						
2	04	270	020		02	00	058						
3	04	241	020		02	00	058						
4	05	391	020		08	00	058						
5	06	391	020		08	00	058						
6	07	391	020		04	00	058						
7	07	266	020		03	00	058						
8	07	241	020		01	00	058						
9	08	266	020		04	00	058						
10	08	241	020		03	00	058						
11	08	252	020		01	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols RNS

ODH Form 4

11

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	238	010		00	40	058						
3	02	238	020		01	20	658						
4	02	391	020		05	00	058						
5	02	266	020		01	00	058						
6	03	391	020		08	00	058						
7	04	266	020		05	00	658						
8	04	270	020		01	00	058						
9	04	241	020		02	00	058				L		
10	05	391	020		08	00	058				F		
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020		08	00	058						
2	09	391	020		06	00	058						
3	09	266	020		02	00	058						
4	10	391	020		08	00	058						
5	11	301	009		08	00	058						
6	12	266	010		00	20	058						
7	12	266	020		02	40	058						
8	12	391	020		05	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	3911	021		08	00	058						
2	16	3911	021		08	00	058						
3	17	3911	021		08	00	058						
4	18	3911	021		04	00	058						
5	18	3911	010		04	00	058						
6	19	3911	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols JNB

6

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	3911	020		08	00	058						
2	23	3911	020		08	00	058						
3	24	3911	020		08	00	058						
4	25	3011	009		08	00	058						
5	26	3011	009		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols LNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Nancy C. Horton

Social Security Number ~~PERSONAL IDENTIFIER(S)~~ REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	020		07	40	058						
2	29	391	010		00	20	058						
3	30	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNS

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	010		00	40	058						
2	13	391	020		07	20	058						
3	14	391	020		08	00	058						
4	15	391	020		08	00	058						
5	16	391	010		00	20	058						
6	16	391	020		07	40	058						
7	17	266	010		00	20	058						
8	17	266	020		02	40	058						
9	17	391	020		05	00	058						
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FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols JAN

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		08	00	058						
2	21	391	020		08	00	058						
3	22	391	004		08	00	058						
4	23	266	020		03	00	058						
5	23	391	020		02	00	058						
6	23	241	020		03	00	058						
7	24	391	009		08	00	058						
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FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols/JK

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number -PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		08	00	058						
2	28	391	010		01	00	058						
3	28	391	021		07	00	058						
4	29	391	010		01	00	058						
5	29	391	021		07	00	058						
6	30	391	020		08	00	058						
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FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols

7

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number — PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	391	020		08	00	058						
2	04	391	020		08	00	058						
3	05	391	020		08	00	058						
4	06	391	020		07	00	058						
5	06	266	020		01	00	058						
6	07	391	020		08	00	058						
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ENTERED
FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols MLB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	020		07	40	058						
2	10	241	020		00	20	058						
3	11	391	020		08	00	058						
4	12	391	020		08	00	058						
5	13	266	020		04	00	058						
6	13	241	020		03	00	058						
7	13	340	020		01	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols LNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	301	009		08	00	058						
2	18	391	020		08	00	058						
3	19	391	010		01	40	058						
4	19	391	020		06	20	058						
5	20	391	020		08	00	058						
6	21	391	010		06	40	058						
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MAR 22 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols
NCB

OPH Form 4

6

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	004		08	00	058						
2	25	391	020		08	00	058						
3	26	391	004		08	00	058						
4	27	391	020		08	00	058						
5	28	391	020		08	00	058						
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MAR 22 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNS

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	31	391	020		08	00	038						
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ENTERED
MAR 22 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols MD

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	010		00	40	058						
4	03	391	020		06	00	058						
5	03	241	020		00	20	058						
6	03	266	020		01	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols GLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	010		00	40	058						
2	07	391	020		07	20	058						
3	08	391	020		08	00	058						
4	09	391	010		00	40	058						
5	09	391	020		07	20	058						
6	10	391	020		08	00	058						
7	11	391	010		00	40	058						
8	11	391	020		07	20	058						
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MAY 25 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNS

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	3911	020		08	00	058						
2	15	3911	020		08	00	058						
3	16	3911	020		08	00	058						
4	17	3911	010		00	40	058						
5	17	3911	020		07	20	058						
6	18	3911	020		07	40	058						
7	18	2411	020		00	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	301	009		08	00	058						
2	22	391	010		00	20	058						
3	23	391	020		07	40	058						
4	23	391	020		08	00	058						
5	24	391	020		07	20	058						
6	24	391	010		00	40	058						
7	25	391	020		07	00	058						
8	25	391	010		01	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	391	020		08	00	058						
2	29	391	020		07	20	058						
3	29	391	010		00	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols NLB

OSH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		01	00	058						
2	01	391	020		07	00	058						
3	02	391	020		07	00	058						
4	02	391	010		01	00	058						
5	03	391	010		01	00	058						
6	03	391	020		07	00	058						
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ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	020		08	00	058						
2	07	391	020		08	00	058						
3	08	391	020		08	00	058						
4	09	391	020		03	00	058						
5	09	301	002		05	00	058						
6	10	391	020		08	00	058						
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ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols RNC

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 6 3 Year 0 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	010		01	00	058						
2	13	391	020		07	00	058						
3	14	391	010		00	20	058						
4	14	391	020		07	40	058						
5	15	391	010		00	40	058						
6	15	391	020		07	20	058						
7	16	391	010		00	20	058						
8	16	391	020		07	40	058						
9	17	391	020		03	00	058						
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ENTERED
JUN 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		07	40	058						
2	20	391	010		00	20	058						
3	21	391	020		08	00	058						
4	22	391	020		08	00	058						
5	23	391	020		08	00	058						
6	24	391	020		08	00	058						
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ENTERED
JUN 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature June Ann Nichols NB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		08	00	058						
2	28	391	020		07	20	058						
3	28	391	010		00	40	058			ENTERED			
4	29	391	020		08	00	058			JUN 05 2000			
5	30	391	020		08	00	058			TIME & EFFORT			
6	31	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols NLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	391	020		08	00	058						
2	04	391	020		07	00	058						
3	04	391	010		01	00	058						
4	05	391	020		07	00	058						
5	05	391	010		01	00	058						
6	06	391	020		08	00	058						
7	07	391	020		07	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	010		00	20	058						
2	10	391	020		07	40	058						
3	11	391	010		00	20	058						
4	11	391	020		07	40	058						
5	12	391	010		00	40	058						
6	12	391	020		07	20	058						
7	13	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CMB

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	020		08	00	058						
2	18	391	020		07	00	058						
3	18	391	010		01	00	058						
4	19	391	010		01	00	058						
5	19	391	020		07	00	058						
6	20	391	020		07	00	058						
7	20	391	010		01	00	058						
8	21	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols RNC

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		08	00	058						
2	25	391	010		00	20	058						
3	25	391	020		07	40	058						
4	26	391	010		00	20	058						
5	26	391	020		07	40	058						
6	27	391	020		08	00	058						
7	28	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	020		08	00	058						
4	04	391	020		07	20	058						
5	04	391	010		00	40	058						
6	05	391	020		07	40	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Month 05 Year 00

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIERS REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020		08	00	058						
2	09	391	020		08	00	058						
3	10	391	020		08	00	058						
4	11	266	020		05	00	058						
5	11	241	020		03	00	058						
6	12	266	020		02	00	058						
7	12	266	010		00	20	058						
8	12	391	020		05	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature JoAnn Nichols NLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	391	020		08	00	058						
2	16	391	020		07	20	058						
3	16	391	010		00	40	058						
4	17	391	020		07	40	058						
5	17	391	010		00	20	058						
6	18	391	020		08	00	058						
7	19	301	004		08	00	058						
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ENTERED
AUG 07 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols LNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

PERSONAL IDENTIFIER(S) REDACTED

Social Security Number —

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	020		08	00	058						
2	23	391	020		08	00	058						
3	24	391	010		09	00	058						
4	24	391	020		01	00	058						
5	25	391	010		00	20	058						
6	25	391	020		07	40	058						
7	26	391	020		08	00	058						
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ENTERED
AUG 07 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols NCB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	301	009		08	00	058						
2	30	391	020		08	00	058						
3	31	391	020		08	00	058						
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ENTERED
AUG 07 2008
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols
JAN

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	39 [redacted]	020		08	00	058						
2	02	391	020		08	00	058						
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SEP 2 1 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols
CNS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	020		08	00	058						
2	06	391	020		08	00	058						
3	07	391	020		08	00	058						
4	08	391	020		08	00	058						
5	09	391	010		01	00	058						
6	09	391	020		07	00	058						
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SEP 21 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols CNS

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	391	010		07	20	058						
2	12	391	010		00	40	058						
3	13	391	010		00	20	058						
4	13	391	020		00	40	058						
5	14	391	010		00	40	058						
6	14	391	020		07	20	058						
7	15	391	010		00	20	058						
8	15	391	020		07	40	058						
9	16	391	020		07	20	058						
10	16	391	010		00	40	058						
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ENTERED
SEP 01 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature JaneAnn Nichols nb

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	391	020		08	00	058						
2	20	391	020		07	40	058						
3	20	391	010		[illegible]		058						
4	21	391	020		[illegible]		058						
5	22	391	020		[illegible]		058						
6	22	391	010		01	00	058						
7	23	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols MB

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	010		00	20	058						
2	26	391	020		06	00	058						
3	26	266	020		01	00	058						
4	26	241	020		00	40	058						
5	27	391	020		08	00	058						
6	28	391	020		08	00	058						
7	29	391	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols fch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	03	391	020		08	00	058						
2	04	301	009		08	00	058						
3	05	391	020		08	00	058			ENTERED			
4	06	301	002		08	00	058			OCT 2 6 2000			
5	07	301	002		08	00	058			TIME & EFFORT			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNS

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	020		0840		058						
2	18	391	010		0020		058						
3	18	391	020		0840		058						
4	19	391	010		0020		058						
5	19	391	020		0840		058						
6	20	391	020		0800		058						
7	21	391	020		0800		058						
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ENTERED
OCT 26 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	010		00	20	058						
2	24	391	020		08	20	058						
3	25	391	020		08	00	058						
4	26	391	010		01	00	058			ENTERED			
5	26	391	020		07	00	058			OCT 26 2000			
6	27	391	010		00	20	058			TIME & EFFORT			
7	27	391	020		09	00	058						
8	28	391	010		00	20	058						
9	28	391	020		08	40	058						
10	29	391	010		00	20	058						
11	29	391	020		07	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED_

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	31	391	020		08	00	058						
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OCT 26 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number [SOCIAL SECURITY NUMBER(S) REDACTED]

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		00	20	058						
2	01	391	020		07	40	058						
3	02	391	010		00	20	058						
4	02	391	020		07	40	058						
5	03	391	010		00	20	058						
6	03	391	020		08	40	058						
7	04	391	010		00	40	058						
8	04	391	020		07	20	058						
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ENTERED
NOV 09 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Jane Ann Nichols MS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	010		00	20	058						
2	07	391	020		09	20	058						
3	08	391	010		00	20	058						
4	08	391	020		09	40	058						
5	09	391	010		00	20	058						
6	09	391	020		09	40	058						
7	10	391	010		00	20	058						
8	10	391	020		11	00	058						
9	11	391	010		00	20	058						
10	11	391	020		09	40	058						
11	12	391	010		00	20	058						
12	12	391	020		09	20	058						
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ENTERED
NOV 09 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	010		00	40	058	1					
2	14	391	020		10	40	058						
3	15	391	010		01	40	058						
4	15	391	020		07	20	058						
5	16	391	010		00	40	058						
6	16	391	020		07	20	058						
7	16	301	008		03	00	058						
8	17	301	008		08	00	058						
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ENTERED
NOV 09 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	020		08	40	058						
2	22	391	010		00	40	058						
3	22	391	020		11	20	058						
4	23	391	010		00	20	058						
5	23	391	020		08	40	058						
6	24	391	010		00	20	058						
7	24	391	020		12	00	058						
8	25	391	010		00	20	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

PERSONAL IDENTIFIER(S) REDACTED

Social Security Number _ _

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	3911	020		08	00	058						
2	29	3911	020		08	40	058						
3	30	3911	010		00	20	058						
4	30	3911	020		07	00	058						
5	30	3011	008		00	40	058			ENTERED			
6	31	3911	010		00	40	058			NOV 0 7 2000			
7	31	3911	020		08	20	058			TIME & EFFORT			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
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NOV 2 8 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	301	009		08	00	058						
2	05	391	020		08	00	058						
3	06	391	010		00	40	058						
4	06	391	020		07	20	058						
5	07	391	010		00	20	058						
6	07	391	020		07	40	058						
7	08	391	010		00	20	058						
8	08	391	020		06	20	058			ENTERED			
9	08	301	008		01	20	058			NOV 28 2000			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Janice Linn

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	301	008		08	00	058						
2	12	301	008		08	00	058						
3	13	301	008		08	00	058						
4	14	301	008		08	00	058						
5	15	391	010		00	40	058						
6	15	391	020		07	20	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	020		08	20	058						
2	19	391	020		09	00	058						
3	19	391	010		00	40	058						
4	20	391	020		08	00	058						
5	21	391	020		08	20	058						
6	22	391	021		05	40	058						
7	22	301	010		01	20	058						
8	22	301	008		01	00	058						
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DEC 12 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	391	020		08	00	058	1					
2	26	391	020		08	00	058						
3	27	391	020		08	00	058						
4	28	391	020		08	00	058						
5	29	391	020		07	40	058						
6	29	391	010		00	20	058						
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ENTERED
NOV 28 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number ~~PERSONAL IDENTIFIER(S) REDACTED~~

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

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DEC 30 1999
TIME & EFFORT

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
YKB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	020		08	00	058						
2	05	391	021		04	00	058						
3	05	391	010		01	00	058						
4	05	391	020		03	00	058						
5	06	391	020		08	00	058						
6	07	391	020		04	00	058						
7	07	391	021		04	00	058						
8	08	391	020		06	00	058						
9	08	391	021		02	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	020		08	00	058						
2	12	391	020		08	00	058						
3	13	391	020		08	00	058						
4	14	391	020		06	00	058						
5	14	391	021		02	00	058						
6	15	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
JAN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	020		04	00	058						
2	18	266	021		04	00	058						
3	19	391	021		04	00	058						
4	19	266	021		04	00	058						
5	20	391	020		04	00	058						
6	20	266	021		04	00	058						
7	21	301	003		08	00	058						
8	22	391	020		04	00	058						
9	22	391	021		04	00	058						
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DEC 22 1999
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	391	020		06	00	058						
2	25	2388	020		02	00	058						
3	26	391	020		06	00	058						
4	26	2388	020		02	00	058						
5	27	391	021		04	06	058						
6	27	391	020		04	00	058						
7	28	391	020		05	00	058						
8	28	2388	020		03	00	058						
9	29	391	020		08	00	058						
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JAN 10 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	238	020		02	00	058						
3	02	391	020		06	00	058						
4	03	391	021		02	00	058						
5	03	391	020		06	00	058						
6	04	391	020		08	00	058						
7	05	391	010		06	00	058						
8	05	391	021		02	00	058						
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ENTERED
FEB 07 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020		08	00	058						
2	09	391	020		05	00	058						
3	09	391	021		03	00	058						
4	10	391	020		08	00	058						
5	11	301	009		08	00	058						
6	12	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	391	020		05	40	058						
2	15	391	010		02	20	058						
3	16	391	021		02	00	058						
4	16	391	020		06	00	058						
5	17	391	020		08	00	058						
6	18	391	021		08	00	058						
7	19	301	002		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	020		08	00	058						
2	23	391	020		08	00	058						
3	24	391	020		08	00	058						
4	25	301	009		08	00	058						
5	26	301	009		08	00	058						
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FEB 04 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MD

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Month 11 Year 99

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	020		08	00	058						
2	30	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	3911	020		08	00	058						
2	02	3911	010		01	00	058						
3	02	3911	021		05	00	058						
4	02	3911	020		02	00	058						
5	03	3911	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
YKS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

J3

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	020		08	00	058						
2	07	301	003		08	00	058						
3	08	391	020		08	00	058						
4	09	391	020		05	00	058						
5	09	391	021		03	00	058						
6	10	391	020		05	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols RNB

ODH Form 4

3

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	020		08	00	058						
2	14	391	020		08	00	058						
3	15	391	021		06	00	058						
4	15	391	010		02	00	058						
5	16	391	020		08	00	058						
6	17	391	020		08	00	058						
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ENTERED
FEB 2 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols UNS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		08	00	058						
2	21	391	020		08	00	058						
3	22	391	020		08	00	058						
4	23	391	020		08	00	058						
5	24	301	009		08	00	058						
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FEB 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nuckolls

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 99

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		08	00	058						
2	28	391	020		06	00	058						
3	28	391	010		02	00	058						
4	29	391	020		06	00	058						
5	29	391	010		02	00	058						
6	30	391	021		08	00	058						
7	31	301	009		08	00	058						
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ENTERED
FEB 2 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

ODH Form 4

6

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	391	020		08	00	058						
2	04	391	020		08	00	058						
3	05	391	020		08	00	058						
4	06	391	020		08	00	058						
5	07	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MLB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	020		08	00	058						
2	11	391	020		08	00	058						
3	12	391	020		08	00	058						
4	13	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	009		08	00	058						
2	18	391	020		08	00	058						
3	19	391	021		04	00	058						
4	19	391	010		02	00	058						
5	19	391	020		02	00	058						
6	20	391	020		08	00	058						
7	21	391	020		08	00	058						
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MAR 24 2000

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		08	00	058						
2	25	391	020		08	00	058						
3	26	301	004		04	00	058						
4	26	391	020		04	00	058						
5	27	391	020		08	00	058						
6	28	301	004		02	00	058						
7	28	391	020		06	00	058						
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MAR 24 2011

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols GNB

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	31	391	020		08	00	058						
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MAR 24 2001

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	004		08	00	058						
2	02	391	020		08	00	058						
3	03	391	010		01	20	058						
4	03	391	020		06	40	058						
5	04	391	010		01	20	058						
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MAY 24 2000

TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

OSH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	020		08	00	058						
2	08	391	020		08	00	058						
3	09	391	020		08	00	058						
4	10	391	020		08	00	058						
5	11	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

ENTERED
MAY 24 2000
TIME & EFFORT

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	39	010		01	00	058						
2	14	39	020		07	00	058						
3	15	39	010		01	20	058						
4	15	39	020		06	40	058						
5	16	39	010		01	00	058						
6	16	39	020		07	00	058						
7	17	39	010		02	40	058						
8	17	39	020		05	20	058						
9	18	39	020		08	00	058						
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ENTERED
JUN 16 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

OUH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	3011	009		08	00	058						
2	22	3911	010		00	20	058						
3	22	3911	020		07	40	058						
4	23	3911	010		01	00	058						
5	23	3911	021		07	00	058						
6	24	3911	010		01	00	058						
7	24	3911	021		07	00	058						
8	25	3911	010		02	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNS

OSH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	391	010		01	20	0058						
2	29	391	020		06	40	0058						
3	29	391	010		03	00	0058						
4	29	391	020		05	00	0058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Janelle Nichols VNB

OSH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page

Employee Susan Waldron

Month 05 Year 10

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		01	00	055						
2	01	391	020		07	00	055						
3	02	391	010		02	00	055						
4	02	391	020		06	00	055			ENTERED			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
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Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	010		03	00	058						
2	06	391	020		05	00	058						
3	07	391	010		01	00	058						
4	07	391	020		04	00	058						
5	07	391	021		03	00	058						
6	08	391	010		00	40	058						
7	08	391	020		07	20	058						
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ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	010		01	20	058						
2	13	391	020		06	40	058						
3	14	391	010		01	00	058						
4	14	391	020		07	00	058						
5	15	391	010		02	00	058						
6	15	391	020		06	00	058						
7	16	391	010		01	00	058						
8	16	391	020		07	00	058						
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JUN 14 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number —PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	3911	020		08	00	058						
2	21	3911	020		08	00	058						
3	22	3911	021		08	00	058						
4	23	3911	021		08	00	058						
5	24	3911	010		01	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		08	00	058						
2	28	391	010		01	00	058						
3	28	391	020		07	00	058						
4	29	391	020		07	00	058						
5	29	391	010		01	00	058						
6	30	391	010		02	00	058						
7	30	391	020		06	00	058						
8	31	391	010		01	00	058						
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ENTERED
JUN 05 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JAN

OSH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	3911	020		08	00	058						
2	04	3911	010		01	00	058						
3	04	3911	020		07	00	058						
4	05	3911	010		01	00	058						
5	05	3911	020		07	00	058						
6	06	3911	020		08	00	058						
7	07	3911	010		01	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols RNS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 06

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	020		07	00	058						
2	10	391	010		01	00	058						
3	11	391	020		07	20	058						
4	11	391	030		00	40	058						
5	12	391	010		01	00	058						
6	12	391	020		07	00	058						
7	13	391	010		01	00	058						
8	13	391	020		07	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	010		01	00	058						
2	17	391	020		07	00	058						
3	18	391	010		01	00	058						
4	18	391	020		07	00	058						
5	19	391	010		01	20	058						
6	19	391	020		06	40	058						
7	20	391	010		01	20	058						
8	20	391	020		06	40	058						
9	21	391	010		01	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	010		01	00	058						
2	24	391	020		07	00	058						
3	25	391	010		01	00	058						
4	25	391	020		07	00	058						
5	26	391	010		01	00	058						
6	26	391	020		07	00	058						
7	27	391	020		08	00	058						
8	28	391	010		02	40	058						
9	28	391	020		05	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		01	00	058						
2	01	391	020		07	00	058						
3	02	391	010		01	00	058						
4	02	391	020		07	00	058						
5	03	391	010		01	00	058						
6	03	391	020		07	00	058						
7	04	391	010		02	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature JaneAnn Nichols (via)

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020		08	00	058						
2	09	391	020		08	00	058						
3	10	391	010		01	00	058						
4	10	391	020		07	00	058						
5	11	391	010		01	40	058						
6	11	391	020		06	20	058						
7	12	391	010		01	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JAN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	391	010		03	40	058						
2	15	391	020		04	20	058						
3	16	391	021		08	00	058						
4	17	391	021		08	00	058			ENTERED			
5	18	391	021		08	00	058			AUG 04 2000			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	020		07	00	058						
2	22	391	010		01	00	058						
3	23	391	020		07	00	058						
4	23	391	010		01	00	058						
5	24	391	020		07	00	058						
6	24	391	010		01	00	058						
7	25	391	010		03	00	058						
8	25	391	021		05	00	058						
9	26	391	021		08	00	058						
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18													

ENTERED
AUG 04 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan A. Waldron

Supervisor's Signature Jane Ann Nichols JNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	301	009		08	00	058						
2	30	391	010		01	00	058						
3	30	391	020		07	00	058						
4	31	391	010		01	00	058						
5	31	391	020		07	00	058						
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ENTERED
AUG 04 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
vnb

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	01	391	010		01	00	058						
2	01	391	020		07	00	058						
3	02	391	010		02	00	058						
4	02	391	020		06	00	058						
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17													
18													

ENTERED
SEP 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MS

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	05	391	020		08	00	058			ENTERED			
2	06	391	010		01	00	058			SEP 19 2000			
3	06	391	020		07	00	058			TIME & EFFORT			
4	07	391	020		08	00	058						
5	08	391	010		01	00	058						
6	08	391	020		07	00	058						
7	09	301	002		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols MB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	12	3901	002		08	00	058			ENTERED			
2	13	3901	010		01	00	058			SEP 29 2000			
3	13	3901	020		07	00	058			TIME & EFFORT			
4	14	3901	010		01	20	058						
5	14	3901	020		06	40	058						
6	15	3901	010		01	00	058						
7	15	3901	020		07	00	058						
8	16	3901	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNS

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	391	020		08	00	058			ENTERED			
2	20	391	010		00	40	058			SEP 29 2000			
3	20	391	020		07	20	058			TIME & EFFORT			
4	21	391	020		08	00	058						
5	22	391	010		01	20	058						
6	22	391	020		06	40	058						
7	23	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols LNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	26	391	010		01	00	058						
2	26	391	020		07	00	058						
3	27	391	010		01	00	058						
4	27	391	020		07	00	058						
5	28	301	003		08	00	058						
6	29	301	003		08	00	058						
7	30	301	003		08	00	058						
8													
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15													
16													
17													
18													

ENTERED
SEP 29 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	301	003		08	00	058						
2	04	301	009		08	00	058						
3	05	391	020		08	00	058						
4	06	391	010		01	00	058						
5	06	391	020		03	00	058						
6	06	301	003		04	00	058						
7	07	391	010		01	00	058						
8	07	391	020		07	00	058						
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16													
17													
18													

ENTERED
NOV 0 1 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols GNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron [redacted]

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1													
2													
3													
4													
5	12	30	1008		02	00	058						
6	13	39	1020		07	00	058						
7	13	39	1010		01	00	058						
8	14	39	1020		08	00	058						
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15													
16													
17													
18													

RECEIVED
OCT 02 2000
TIME & EFFT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols LMB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	020		08	00	058						
2	11	391	020		11	00	058						
3	11	391	010		01	00	058						
4	12	391	020		06	00	058						
5	13	391	020		07	00	058						
6	13	391	010		01	00	058						
7	14	391	020		08	00	058						
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14													
15													
16													
17													
18													

ENTERED
NOV 13 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols RNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number [PERSONAL IDENTIFIERS REDACTED]

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	020		08	00	058						
2	18	391	020		08	00	058						
3	19	391	021		06	00	058						
4	19	391	010		02	00	058						
5	20	391	020		08	00	058						
6	21	391	020		07	20	058						
7	21	391	010		00	40	058						
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ENTERED
NOV 0 4 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols RNS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron Amended

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		08	00	058						
2													
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OCT 02 2000

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		08	20	058						
2	24	391	010		01	00	058						
3	25	391	020		06	00	058						
4	25	301	008		~~02~~	~~00~~	058						
5	26	391	010		01	20	058						
6	26	391	020		06	40	058						
7	27	391	010		01	00	058			ENTERED NOV 0 2 2000 TIME & EFFORT			
8	27	391	020		08	40	058						
9	28	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols tch

OOH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIERS REDACTED

Month 07 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	31	391	010		00	40	058						
2	31	391	020		07	20	058						
3													
4													
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18													

ENTERED
NOV 0 3 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols tch

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1 of 1

Employee Susan Waldron

Social Security Number [PERSONAL IDENTIFIERS REDACTED]

Month 08 Year 06

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		00	20	058						
2	01	391	020		07	40	058						
3	02	391	020		08	00	058						
4	03	391	010		00	40	058				ENTERED		
5	03	391	020		07	20	058				NOV 09 2006		
6	04	391	010		02	00	058				TIME & EFFORT		
7	04	391	021		07	40	058						
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number [redacted]

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	010		00	40	058				ENTERED		
2	07	391	020		07	20	058				NOV 0 9 2000		
3	07	391	021		01	00	058				TIME & EFFORT		
4	08	391	010		01	00	058						
5	08	391	020		07	00	058						
6	09	391	010		00	40	058						
7	09	391	020		07	20	058						
8	10	391	010		00	40	058						
9	10	391	020		09	20	058						
10	11	391	010		01	20	058						
11	11	391	020		06	40	058						
12	12	391	010		00	40	058						
13	12	391	020		08	00	058						
14													
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number ___

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	010		0140	058							
2	14	391	020		0900	058							
3	14	391	021		0200	058					ENTERED		
4	15	391	020		0700	058					NOV 0 9 2000		
5	15	391	010		0200	058					TIME & EFFORT		
6	16	391	010		0220	058							
7	16	391	020		0920	058							
8	17	391	020		0800	058							
9	18	238	010		0700	058							
10	18	238	021		0540	058							
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number [redacted]

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	020		04	00	058						
2	21	391	021		04	00	058						
3	22	391	021		01	40	058						
4	22	391	010		01	00	058						
5	22	391	020		07	20	058						
6	23	391	010		00	40	058						
7	23	391	020		12	00	058						
8	24	391	010		00	40	058						
9	24	391	021		07	00	058						
10	24	391	020		04	00	058						
11	25	391	010		01	00	058						
12	25	391	021		03	00	058						
13	25	391	020		06	00	058						
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ENTERED
NOV 0 9 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number [PERSONAL IDENTIFIERS REDACTED]

Month 08 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	391	021		04	00	058						
2	28	391	020		04	00	058						
3	29	391	021		04	00	058						
4	29	391	020		02	00	058				ENTERED		
5	29	301	008		~~02~~	~~00~~	058				NOV 0 - 2000		
6	30	391	010		00	40	058				TIME & EFFORT		
7	30	391	020		04	00	058						
8	30	391	021		03	20	058						
9	31	391	010		01	40	058						
10	31	391	020		04	20	058						
11	31	391	021		02	00	058						
12													
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2													
3													
4													
5										ENTERED			
6										NOV [illegible], 00			
7										TIME & EFFOR			
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	301	009		08	00	058						
2	05	391	020		08	00	058						
3	06	301	008		08	00	058			ENTERED			
4	07	301	008		08	00	058			NOV x 9 2000			
5	08	301	008		08	00	058			TIME & EFFORT			
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER REDACTED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	301	008		08	00	058						
2	12	301	008		04	40	058						
3	12	391	010		03	20	058						
4	13	391	021		~~08~~	00	058	AMENDED			ENTERED		
5	14	391	021		~~08~~	00	058	"			DEC 11 2000		
6	15	391	010		~~03~~	20	058	"			TIME & EFFORT		
7	15	391	021		~~07~~	00	058	"					
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17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER SUPPLIED

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1													
2													
3													
4	13	3911	010		00	20	058						
5	13	3911	021		07	40	058						
6	14	3911	010		00	20	058						
7	14	3911	021		07	40	058						
8	15	3911	010		03	40	058						
9	15	3911	021		07	00	058						
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number _

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	238	010		01	20	058						
2	18	238	020		02	40	058						
3	18	391	021		04	40	058			ENTERED			
4	19	391	010		00	40	058			DEC 11 2000			
5	19	391	020		08	20	058			TIME & EFFORT			
6	20	391	020		08	00	058						
7	21	391	010		00	40	058						
8	21	391	020		07	20	058						
9	22	301	010		01	20	058						
10	22	301	021		05	40	058						
11	22	391	021		01	00	058						
12													
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18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number [redacted]

Month 09 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	25	391	010		01	20	058						
2	25	391	020		06	40	058						
3	26	391	020		08	00	058						
4	27	391	020		08	00	058			ENTERED			
5	28	391	020		04	00	058			NOV - 0 2000			
6	28	301	002		04	00	058			TIME & EFFORT			
7	29	391	010		02	00	058						
8	29	391	021		06	00	058						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee [illegible], RN

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 04

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	340	020		02	20	058						
2	10	266	020		02	00	058						
3	10	241	020		02	00	058						
4	10	270	020		02	00	058						
5	11	241	020		08	20	058						
6	12	241	020		08	20	058						
7	13	340	020		02	20	058						
8	13	266	020		02	00	058						
9	13	241	020		02	00	058						
10	13	252	020		02	00	058						
11	14	340	020		02	20	058						
12	14	252	020		02	00	058						
13	14	275	020		02	00	058						
14	14	391	020		02	00	058	1					
15	15	340	021		01	00	058						
16	15	241	021		01	00	058						
17	15	270	021		01	00	058						
18	15	275	021		01	00	058						

ENTERED
NOV 08 2004
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [illegible], RN

Supervisor's Signature Jane Ann Nichols MD

FEES

9/29/1999 to 9/28/2000

Claims	8,866.03
PROGCOST - Fees	711.24
Total Fees	$ 9,577.27

Claims are the direct costs and PROGCOST are the allocated costs. These are costs for professional services. Examples might be things like developing curricula for training materials or speaker fees. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

Time And Effort Cost
Cost Accumulation Schedule

December 27, 2000
Prepared By _____

Grant Name: Conduct Site Specific Activity
Grant Number U50 / ATU686520-02
Grant Period 09/29/1999 TO 09/28/2000
Program Code 391
[redacted]

Year\Month	FEES	TRAVEL	EQUIP	OTHER
199910	29.95	68.29	0.00	314.40
199911	33.83	113.54	0.00	460.20
199912	57.01	111.23	0.00	365.45
200001	82.48	85.09	0.00	570.89
200002	80.00	113.40	0.00	563.74
200003	49.32	90.19	0.00	448.55
200004	37.03	55.69	0.00	288.52
200005	48.98	95.39	0.00	399.42
200006	54.81	75.95	0.00	577.69
200007	55.18	23.25	0.00	259.16
200008	60.18	65.22	0.00	681.65
200009	49.33	93.79	0.00	461.43
Total	**638.10**	**991.03**	**0.00**	**5,371.10**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
199910	4.17	9.51	0.00	43.76
199911	3.43	11.53	0.00	46.73
199912	6.65	12.97	0.00	42.62
200001	12.24	12.63	0.00	84.73
200002	8.67	12.29	0.00	61.10
200003	5.38	9.83	0.00	48.90
200004	4.02	6.04	0.00	31.30
200005	5.67	11.03	0.00	46.21
200006	5.62	7.79	0.00	59.24
200007	5.82	2.45	0.00	27.34
200008	6.13	6.65	0.00	67.44
200009	5.34	10.15	0.00	49.96
Total	**73.14**	**112.87**	**0.00**	**609.33**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
34.12	77.80	0.00	358.16
37.26	125.07	0.00	506.93
63.66	124.20	0.00	408.07
94.72	97.72	0.00	655.62
88.67	125.69	0.00	624.84
54.70	100.02	0.00	497.45
41.05	61.73	0.00	319.82
54.65	106.42	0.00	445.63
60.43	83.74	0.00	636.93
61.00	25.70	0.00	286.50
66.31	71.87	0.00	729.09
54.67	103.94	0.00	511.39
[redacted]	[redacted]	[redacted]	[redacted]

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T025662	104066

FOR AGENCY USE WARRANT # 7127847 DATE: 08/14/2000

CLAIM OF:
SE KANSAS EDUC SVC CENTER
480844933

1 0 4 0 6 6

FOR $ 4,854.00

AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	1511	000000000	4,854.00

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	4,854.00
001		OSF-AUDITED BY	

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001130

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/30/1999	H55370149	4,854.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 1511AAAAAX 4854.00

J/E XREF:

VENDOR: SE KANSAS EDUC SVC CENTER
ADDRESS: PO BOX 189
ADDRESS:
CITY/ST/ZIP: GIRARD KS 667430189

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

08/08/2000
Date

Agency, Bd or Div. Use

SOUTHEAST KANSAS EDUCATION SERVICE CENTER
PO BOX 189
GIRARD KANSAS 66743 - 0189
316 - 724 - 6281

1040666 MT

OK

SOLD TO: OKLA. STATE DEPT OF HEALTH - ACCTS PAYABLE
1000 NE 10TH STREET
OKLAHOMA CITY OK 73117-1299

INVOICE NO H5-5370 - 149
INVOICE DATE NOV 1999 & JULY 2000 *
YOUR PO T025662

LEAD POISONING PREVENTION CURRICULA

QTY	ITEMS	UNIT PRICE	TOTAL
	FEE TO DEVELOP CURRICULA FOR PRESCHOOL TO 12TH GRADES		
	RATES PER BID RESPONSE ARE AS FOLLOWS:		
6	DAYS CONSULTANT WORK BY OUR SHERRY REED	500.00	3000.00
800	MILES TRAVEL (TWO DAYS) FOR CONSULTANT	0.31	248.00
16	HOURS GRAPHICS TIME TO FINALIZE DOCUMENTS	45.00	720.00
4	TEACHER STIPENDS FOR TWO DAYS CURRICULUM WORK	125.00	500.00
1	ADMINISTRATIVE FEE FOR CONTRACTING	386.00	386.00

OKLAHOMA CONTACT IS GRACE E BROWN

* PLEASE PAY FROM THIS INVOICE ONLY - IT WAS FAXED 7/17/2000
THANK YOU!

T025662	000035 NW 9
PURCHASE DOCUMENT	ACCOUNT NO.
COMPLETE / 001 PARTIAL	400 BT 00
	FUND NO.
42000	1511 A-X
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
[signature]	7/17/00
INVOICE APPROVED	DATE

RECEIVED
JUL 20 2000
Personal Health Finance

PLEASE RETURN INVOICE COPY W/CHECK

sertify this to be an exact Copy of an
ng/Check Invoice.

INVOICE TOTAL 4854.00

ne Original was never sent
FAX copy only

Signature/Date [signature] 8/02/00

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T078931	111669

FOR AGENCY USE
WARRANT # 7380865 DATE: 10/23/2000

CLAIM OF:
INTEGRIS BAPTIST REG HLTH CT
730584411

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	1514	932000000	2,295.00

FOR
$ 2,295.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant:

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	2,295.00
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000825

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
09/18/2000	AUG 2000	2,295.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 1514AAAAAX 2295.00

J/E XREF:

VENDOR: INTEGRIS BAPTIST REG HLTH CTR
ADDRESS: P. O. BOX 1590
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74355

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

10/19/2000

Title Date

Agency, Bd or Div. Use

111669 pr

INVOICE

BAPTIST REGIONAL HEALTH CENTER
Attn: Angel Hill, Accounting
200 2nd S.W. - P.O. Box 1207
Miami, Oklahoma 74355
918-540-7282
FEI # 73-0584411

T078931
PURCHASE DOCUMENT
ACCOUNT #
COMPLETE PARTIAL
FUND NO.
MATH CHECKED
OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
INVOICE APPROVED
DATE

18-Sep-00

OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1299

PO# T078931

SEP 2 5 2000

Period covered @ $135.00/day:		
08/01/2000	JELLY BE	135.00
08/02/2000	PICHER ELEM	135.00
08/03/2000	NICHOLS ELEM	135.00
08/04/2000	QUAPAW ELEM	135.00
08/07/2000	KIDS KAMPUS	135.00
08/08/2000	QUAPAW ELEM	135.00
08/09/2000	MIAMI HEAD START	135.00
08/10/2000	MIAMI HEAD START	135.00
08/11/2000	WILL ROGERS MIDDLE	135.00
08/12/2000	WAL-MART	135.00
08/14/2000	COMMERCE HEAD START	135.00
08/15/2000	WYANDOTTE ELEM	135.00
08/16/2000	AFTON ELEM	135.00
08/22/2000	OTTAWA COUNTY FAIR	135.00
08/23/2000	OTTAWA COUNTY FAIR	135.00
08/24/2000	OTTAWA COUNTY FAIR	135.00
08/25/2000	OTTAWA COUNTY FAIR	135.00

Kyed & Nancy Horton OCHD 9/27/00-kr

If you have questions regarding this invoice please contact Dave Simpson at (918)540-7624.

Previous Balance	
PLEASE PAY THIS AMOUNT	~~$2,295.00~~

T078931 0001354 40080 002 514A-X 42000

RECEIVED BY
SEP 2 5 2000
CONTRACT COORDINATOR
OBJECT CODE
CLAIM NUMBER
APPROVED
DATE

9/27/00 Sgt 10-11-00

Mobile Clinic Usage—August 2000
Ottawa County Health Department

August 1	Jelly Bean Day Care	Miami, OK
August 2	Picher Elementary	Picher, OK
August 3	Nichols Elementary	Miami, OK
August 4	Quapaw Elementary	Quapaw, OK
August 7	Kids Kampus	Miami, OK
August 8	Quapaw Elementary	Quapaw, OK
August 9	Miami Head Start	Miami, OK
August 10	Miami Head Start	Miami, OK
August 11	Will Rogers Middle	Miami, OK
August 12	Wal-Mart	Miami, OK
August 14	Commerce Head Start	Commerce, OK
August 15	Wyandotte Elementary	Wyandotte, OK
August 16	Afton Elementary	Afton, OK
August 22	Ottawa County Fair	Miami, OK
August 23	Ottawa County Fair	Miami, OK
August 24	Ottawa County Fair	Miami, OK
August 25	Ottawa County Fair	Miami, Ok

17 days @ 135 per day =~~$2,240~~

$2295

Ben Callaret

13643

Personal Health

Baptist Regional Health Center | 730584411

Aug 00 | 9/18/00 | $2,295.00

T078931 | Bonnie Hartzell | 9/22/00

For your approval

SEP 25 2000

Public Health Finance

RECEIVED
SEP
FINANCIAL
MCH CONTRACT COORDI

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T078931	109579

FOR AGENCY USE
WARRANT # 7313311 DATE: 10/04/2000

CLAIM OF:
INTEGRIS BAPTIST REG HLTH CT
730584411

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	1514	000000000	810.00

FOR
$ 810.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRE (LOCATO NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		810.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 92000702

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
08/07/2000	AUG000807200	810.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 1514AAAAAX 810.00

J/E XREF:

VENDOR: INTEGRIS BAPTIST REG HLTH CTR
ADDRESS: P. O. BOX 1590
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74355

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

10/02/2000

Title Date

Agency, Bd or Div. Use

105579

INVOICE

BAPTIST REGIONAL HEALTH CENTER
Attn: Angel Hill, Accounting
200 2nd S.W. - P.O. Box 1207
Miami, Oklahoma 74355
918-540-7282
FEI # 73-0584411

Clj 9-7-00

T078931	000185NW99
PURCHASE DOCUMENT	ACCOUNT NO.
001	400BT01
COMPLETE PARTIAL	FUND NO.
V 42000	1514 A-X
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
[signature]	8/28/00
INVOICE APPROVED	DATE

07-Aug-00

OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1299

PO# T078931

Period covered @ $135.00/day:		
07/18/2000 LITTLE ANGELS	LEAD TEST	135.00
07/20/2000 KIDS KAMPUS	LEAD TEST	135.00
07/26/2000 TURTLE TOTS	LEAD TEST	135.00
07/27/2000 JOYFUL LEARNING	LEAD TEST	135.00
07/28/2000 TOT SPOT	LEAD TEST	135.00
07/29/2000 SIDEWALK SALE	LEAD TEST	135.00
If you have questions regarding this invoice please contact Dave Simpson at (918)540-7624.		
Previous Balance		
PLEASE PAY THIS AMOUNT		$ 810.00

RECEIVED
SEP 13 2000
FINANCIAL MANAGEMENT

RECEIVED
SEP 25 2000
FINANCIAL MANAGEMENT

RECEIVED
SEP 07 2000
Personal Health Finance

Financial Management Service

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To: 13536

Personal Health

Baptist Regional Health Center | 730584411

JUL00 | Invoice Date: 8/7/00 | $810.00

Order Number: T078931 | **Audited By:** Jetty Zeigler | **Date Rejected:** 9/18/00

- ☐ Funding Not Indicated
- ☐ Certified Invoice Copy
- ☐ Proof of Delivery
- ☐ Notary Seal Missing
- ☐ Notary Signature Missing
- ☐ Notary County or State Incomplete
- ☐ Notary Expired (Not Valid)
- ☐ Changes Need Justification
- ☐ Changes Need Authorizing Initials
- ☐ Item Not Found

Required Dates

- ☐ Invoice Date Prior to Date of Service
- ☐ Notary Date Prior to Date of Invoice
- ☐ Notary Date Prior to Date of Service

RECEIVED
2000 SEP 27 P 4
FINANCIAL MANAGE

Division Finance Area Comments

Contract Period DATE OF AWARD THRU SEPT 30 2000

Dates of Service 7/18/2000, 7/20/2000, 7/26/2000, 7/27/2000
7/28/2000, 7/29/00 All in July - added

However, Funding for FY 2001 has not been [illegible] - SK

Please Return This Document To Financial Management

KEN CADARET

13046

Personal Health

Baptist Regional Health Center | 730584411

July 2000 | 8/7/00 | $810.00

T078931 | Bonnie Hartzell | 8/17/00

For your approval

36543

RECEIVED
SEP 13 P 4:27
FINANCIAL MANAGEMENT

RECEIVED
SEP 07 2000
Personal Health Finance

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T082766	039057

FOR AGENCY USE
WARRANT # 8209395 DATE: 06/27/2000

CLAIM OF:
THOMAS SCHLENKER
PERSONAL IDENTIFIER(S) REDACTED

0 3 9 0 5 7

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	1511	841810000	907.03

FOR
$ 907.03

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	907.03
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000526

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/28/2000	052000	907.03

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 1511AAAAAX 907.03

J/E XREF:

VENDOR: THOMAS SCHLENKER
ADDRESS:
ADDRESS:
CITY/ST/ZIP: PERSONAL IDENTIFIER(S) REDACTED

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

06/23/2000
Date

Agency, Bd or Div. Use

Thomas Schlenker, MD, MPH

PERSONAL IDENTIFIER(S) REDACTED

RECEIVED BY
PERSONAL IDENTIFIER(S) REDACTED
JUN 2 2000
MCH CONTRACTS COORDINATOR

039057 MT

May 28, 2000

T082766-001

Oklahoma State Department of Health
Maternal and Child Health
ATTN: MCH Contracts Coordinator
1000 NE 10th Street
Oklahoma City, OK 73117-1299

Dear OSDH,

Please reimburse for the following expenses incurred by Dr. Schlenker during his visit to Miami, Oklahoma, May 25-26 to lecture and provide consultation to the Ottawa County Health Department Lead Poisoning Prevention Program.

mileage PP-O'Hare-PP (90 miles x $0.32/mile)	$28.80
tolls	5.40
parking	38.00
rental car	82.43
~~meals~~ Perdiem 33hrs According to Dr. Schlenker 8:00AM 5-25-00 thur 5:00PM 5-26-00 $32.50	~~9.06~~ ~~8.50~~ 9.22
hotel	40.00
postage	21.90
air travel	258.00
Lecture (See Backup)	400.00
TOTAL	~~$498.30~~

RECEIVED
JUN 15 2000
Personal Health Finance

Total $907.03

PERSONAL IDENTIFIER(S) REDACTED

Sincerely,

Thomas Schlenker, MD, MPH
PERSONAL IDENTIFIER(S) REDACTED

CC: Ken Caderet
Susan Waldron

T082766 PURCHASE DOCUMENT	000035N ACCOUNT NO.
E COMPLETE / 001 PARTIAL	400BT00 FUND NO.
92000 MATH CHECKED	1511 A-Y OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
K. Cadera 6/15/00 INVOICE APPROVED	DATE

JUN 2 2000
MCH CONTRACT COORDINATOR

[redacted], MD, MPH

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

May 28, 2000

Oklahoma State Department of Health
Maternal and Child Health
ATTN: MCH Contracts Coordinator
1000 NE 10th Street
Oklahoma City, OK 73117-1209

Dear OSDH,

Please remit honoraria in the amount of $400.00 to Dr. Schlenker for lecture and consultation provided May 25th, 2000 to the Ottawa County Health Department Lead Poisoning Prevention Program.

Sincerely,

Thomas Schlenker, MD, MPH
SS #

PERSONAL IDENTIFIER(S) REDACTED

RECEIVED
JUN 15 2000
Personal Health Finance

CC: Ken Caderet
Susan Waldron

RECEIVED
JUN 2 2000
MCH CONTRACT COORDINATOR

Transportation Authority

5/26/00

2 Axles

$2.50

PIKEPASS Saves Time And Money

+ 8.50
+ 2.40

TULSA INTERNATIONAL AIRPORT

19 MARY $8.50

CHK 2770 MAY26'00 06:13AM GST 0

THANK YOU

O'Hare International Airport

Parking Facility - Lots A, B & C

P.O.Box 66179, Chicago, Il. 60666-0179

Tel: (773) 686-7532

DAILY TICKET - A Lot Level 2 - 6

TRANSACTION NUMBER	301042478
ENTRY TIME/DATE	08:34 05-25-00
PAYMENT TIME/DATE	15:46 05-26-00
PAY MACHINE	CE33
LICENSE:	PERSONAL IDENTIFIER(S) REDACTED
OPERATOR	495
FEE	$38.00
TARIFF #	3
CASH	$40.00
CHANGE	$2.00

Carl's Jr Restaurant

2000-05-25 1:36 PM

0542 3 11 3156

TENT 7

*** Order was Modified ***
*** After Total ***

2 Super Cheese	6.58
Reg Fry	.39
Sm * BevBar	.39
Dine In	8.46
9.00% Tax	.76
Amount Due	$9.22
$20.00	$20.00
Change	$10.78

TULSA INTERNATIONAL AIRPORT

29 DANNYELL

CHK 2145 MAY26'00 07:54AM GST 1

1 CINNAMON ROLL	2.25
1 GOURMET COFF SM	1.50
CASH	5.05
SUBTOTAL	3.75
TAX	0.30
PAYMENT	4.05
CHANGE DUE	1.00

TIP $1.00

1211 Thomas Valentes

ADDRESS PERSONAL IDENTIFIER(S) REDACTED

CITY

REPRESENTING Ottawa Co. Hdq. Dept

LICENSE NO. | STATE | CAR YEAR, MAKE, MODEL

NOTICE TO GUESTS - This property is privately owned and management reserves the right to refuse service to anyone, and will not be responsible for accidents or injury to guests or for loss of money, jewelry or valuables of any kind.

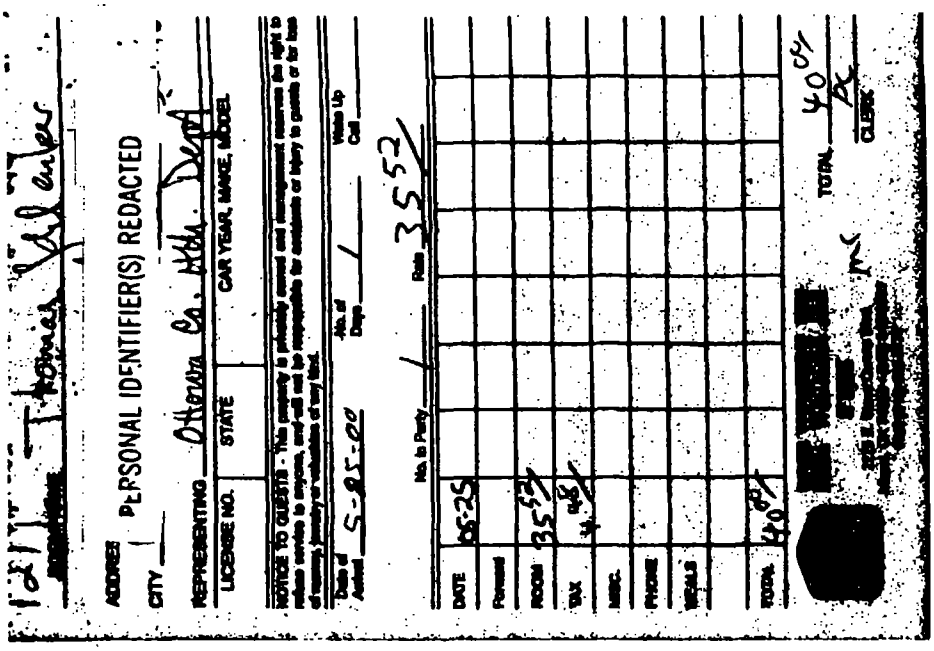
Date of Arrival 5-25-00 | No. of Days 1 | Wake Up Call

No. to Party 1 | Rate 35.52

DATE	05-25
Forward	
ROOM	35.52
TAX	4.48
MISC.	
PHONE	
WEALS	
TOTAL	40.00

TOTAL 40.00 PC

CLERK



THRIFTY RENT-A-CAR SYSTEM, INC.
7777 E. APACHE
TULSA, OK 74115
(918)838-9991

ALL CHARGES SUBJECT TO FINAL AUDIT
LICENSEE:
Open/Exp. 1363 Close/Exp. 1450

Montgomery Ward Car Rental 370101 TUL

Thrifty

CUSTOMER INFORMATION

SCHLENKER THOMAS CUST NO: 356979

PERSONAL IDENTIFIER(S) REDACTED

CHILDREN HOSPITAL
MIAMI BEST WESTERN

ADD'L RENTER:

RESERVATION NO: 321829

(P)AID DEPOSITS:
(A)UTHORIZATIONS
(A) 182.43 MC

I understand that if I decline PDW, I am responsible for all loss regardless of fault. Only an authorized renter may drive the car. Rates are subject to change if the vehicle is not returned as stated above. Minimum one day rental charge. All the information provided to you in connection with this rental is true.

Car To Be Returned To Above Unless Stated
RA OUT: 370101 TUL
RA IN: 370101 TUL

Rental Expires On 8:05
05/26/00 N61166490

PERSONAL IDENTIFIER(S) REDACTED

VEH.#: Vehicle Information
LIC.#:
DODG STRATU
Fuel out 8/8 Mileage o 11783
Fuel in 8/8 Mileage i 11958
EXCH
LIC.#: STALL#:

Fuel out Mileage o
Fuel in Mileage i

MILES DRIVEN: 175

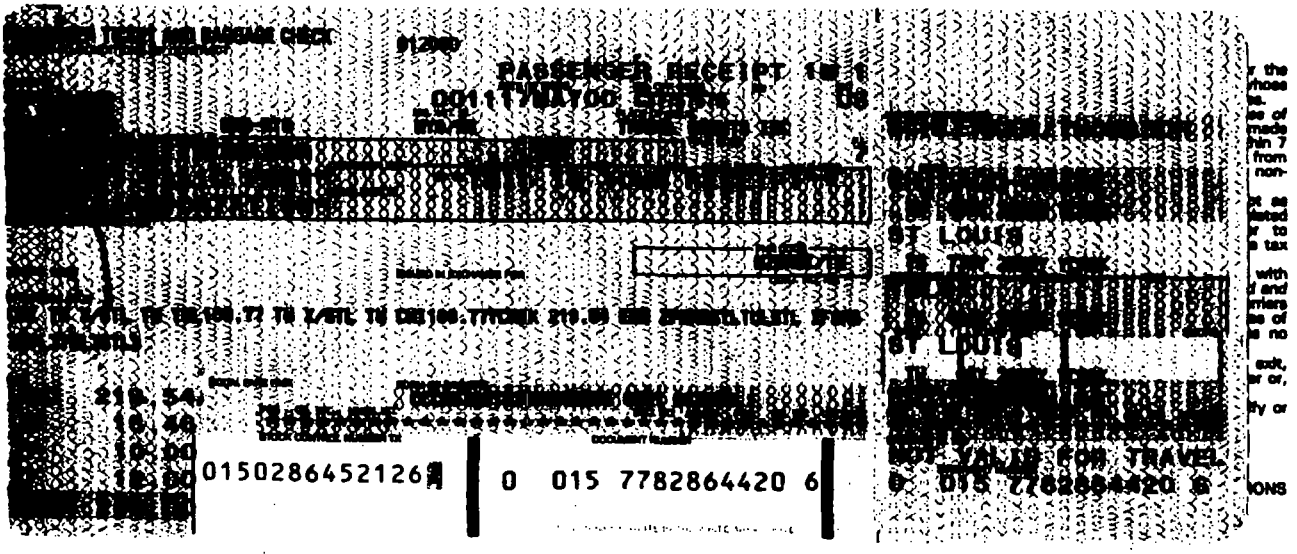
CREDIT CARD EXP. DATE
AUTH # 037207 AMT 182.43
SOURCE: 100 1A

	TIME OUT	TIME IN
	05/25/00 12:47	05/26/00 6:07
Per Mile		
Per Hour	14.97	
Per Day 1	44.90	44.90
Per Week		
Per Month		
Wknd Day		
**NET T & M		44.90
Prepaid Fuel	1.35 P/G	22.95
Drop Fee		
Underage Dr	10.00 per day	
Add'l renter	5.00 per day	
Conc.Red.Fee	10.00 %	4.49
State Surchg	6.00 %	2.96
Sales Tax 1	7.917%	5.73
CFC Chrg	1.40 per day	1.40

* LESS PAID DEPOSITS *
* TOTAL CHARGES 82.43
CREDITS/PAYMENTS
MC 82.43

By signature below, I acknowledge that I have read and agree to the terms and co[illegible]th printed and written, including Physical Damage Waiver, that appear on this rental statement and on the separate rental jacket. All the information provided by Me is true. I know that if I decline the option PDW, I am responsible for all loss regardless of fault. I AUTHORIZE THRIFTY TO PROCESS OR SUBMIT A CHARGE TO MY CREDIT, DEBIT OR CHARGE CARD FOR THE ESTIMATED CHARGES FOR THIS RENTAL UPON MY SIGNING THIS RENTAL STATEMENT AND FOR ALL ADDITIONAL CHARGES UPON RETURN OF THE VEHICLE.

X _____ RENTER SIGNATURE


PASSENGER RECEIPT
ST LOUIS
ST LOUIS
NOT VALID FOR TRAVEL
0150286452126
0 015 7782864420 6
0 015 7782864420 6

59

100

FedEx USA Airbill FedEx Tracking Number 821182490002

1 From Please print and press hard.

Date 5-24-00 Sender's FedEx Account Number 2466-6101-4

Sender's Name Thomas Schlenker Phone (262) 697-4310

Company MAIL BOXES ETC

Address 7528 PERSHING BLVD STE B

Dept./Floor/Suite/Room

City KENOSHA State WI ZIP 53142

2 Your Internal Billing Reference

First 24 characters will appear on invoice

3 To Recipient's Name Kathy Padilla Phone (405) 271-4470

Company Oklahoma State Hth. Dept., Mat. & Child Hth.

Address 1000 NE 10th St.

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Dept./Floor/Suite/Room

To "HOLD" at FedEx location, print FedEx address here

4a Express Package Service — Packages up to 150 lbs.

Delivery commitments may be later in some areas.

- [x] FedEx Priority Overnight — Next business morning
- [ ] FedEx Standard Overnight — Next business afternoon
- [ ] FedEx First Overnight — Earliest next business morning delivery to select locations
- [ ] FedEx 2Day* — Second business day
- [ ] FedEx Express Saver* — Third business day

* FedEx Letter Rate not available. Minimum charge. One-pound rate.

4b Express Freight Service — Packages over 150 lbs.

Delivery commitments may be later in some areas.

- [ ] FedEx 1Day Freight* — Next business day
- [ ] FedEx 2Day Freight — Second business day
- [ ] FedEx 3Day Freight — Third business day

* Call for Confirmation.

5 Packaging — * Declared value limit $500

- [x] FedEx Letter*
- [ ] FedEx Pak*
- [ ] Other Pkg — Includes FedEx Box, FedEx Tube, and customer pkg.

6 Special Handling

- [ ] Saturday Delivery — Available for FedEx Priority Overnight and FedEx 2Day to select ZIP codes
- [ ] Sunday Delivery — Available for FedEx Priority Overnight to select ZIP codes
- [ ] HOLD Weekday at FedEx Location — Not available with FedEx First Overnight
- [ ] HOLD Saturday at FedEx Location — Available for FedEx Priority Overnight and FedEx 2Day to select locations

Does this shipment contain dangerous goods?

- [x] No
- [ ] Yes — As per attached Shipper's Declaration
- [ ] Yes — Shipper's Declaration not required
- [ ] Dry Ice — Dry Ice, 9, UN 1845 ____ x ____ kg
- [ ] Cargo Aircraft Only

Dangerous Goods cannot be shipped in FedEx packaging.

7 Payment Bill to: Enter FedEx Acct. No. or Credit Card No. below

- [x] Sender — Acct. No. in Section 1 will be billed
- [ ] Recipient
- [ ] Third Party
- [ ] Credit Card
- [ ] Cash/Check

FedEx Acct. No. / Credit Card No. — Exp. Date

Total Packages	Total Weight	Total Declared Value*
1	1	$ .00

8 Release Signature — Sign to authorize delivery without obtaining signature

5501 — 351

BECOM

KEEP THIS COPY FOR YOUR RECORDS

**********SALE **********
Mail Boxes Etc.
Making Business Easier. Worldwide.
****
Eft:0148 Drw:01 ID:639 Clerk:[illegible]
24/00

Center #3860
7528 Pershing Blvd.
Suite B
Kenosha, WI 53142
Phone 262-697-4310

y	Description	Unit	Ext
1	FEDEX	21.90	21.90

Sub Total:	21.90
Tax:	0.00
Total Sale:	21.90
Cash:	22.00
Change:	0.10

Visit our Web Site at: WWW.MBE.COM

TRAVEL
9/29/1999 to 9/28/2000

Claims	4,794.29
PROGCOST - Travel	1,103.90
Total Travel	$ 5,898.19

Claims are the direct costs and PROGCOST are the allocated costs. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

Time And Effort Cost
Cost Accumulation Schedule

December 27, 2000
Prepared By _____

Grant Name: Conduct Site Specific Activity
Grant Number U50 / ATU686520-02
Grant Period 09/29/1999 TO 09/28/2000
Program Code 391

[redacted]

Year\Month	FEES	TRAVEL	EQUIP	OTHER
199910	29.95	68.29	0.00	314.40
199911	33.83	113.54	0.00	460.20
199912	57.01	111.23	0.00	365.45
200001	82.48	85.09	0.00	570.89
200002	80.00	113.40	0.00	563.74
200003	49.32	90.19	0.00	448.55
200004	37.03	55.69	0.00	266.52
200005	48.98	95.39	0.00	399.42
200006	54.81	75.95	0.00	577.69
200007	55.18	23.25	0.00	259.16
200008	60.16	65.22	0.00	661.65
200009	49.33	93.79	0.00	461.43
Total	**638.10**	**991.03**	**0.00**	**5,371.10**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
199910	4.17	9.51	0.00	43.76
199911	3.43	11.53	0.00	46.73
199912	6.66	12.97	0.00	42.62
200001	12.24	12.63	0.00	84.73
200002	8.67	12.29	0.00	61.10
200003	5.38	9.83	0.00	48.90
200004	4.02	6.04	0.00	31.30
200005	5.67	11.03	0.00	46.21
200006	5.62	7.79	0.00	59.24
200007	5.82	2.45	0.00	27.34
200008	6.13	6.65	0.00	67.44
200009	5.34	10.15	0.00	49.96
Total	**73.14**	**112.87**	**0.00**	**609.33**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
34.12	77.80	0.00	358.16
37.26	125.07	0.00	506.93
63.68	124.20	0.00	408.07
94.72	97.72	0.00	655.62
88.67	125.69	0.00	624.84
54.70	100.02	0.00	497.45
41.05	61.73	0.00	319.82
54.65	106.42	0.00	445.83
60.43	83.74	0.00	636.93
61.00	25.70	0.00	286.50
66.31	71.67	0.00	729.09
54.67	103.94	0.00	511.39
711.24	[redacted]	**0.00**	**5,969.43**

OSF Form 19 (Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
~~HSP~~ BTCD	340		031879 dl

FOR AGENCY USE: BTCD NLC97 N4198S

CLAIM OF: KAREN CORNELL

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

Main PR

285.75

FOR

~~299.04~~

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

IS CAR GOV. OWNED? YES ____ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
19185	4000	2111	93200 0	84.50
		2112		81.25
		2115		~~133.29~~
				120.00
				285.75

OSF - Audited By:

TOTAL AMOUNT $ ~~299.04~~

OFFICIAL DUTY STATION: STILWELL

NATURE OF OFFICIAL BUSINESS: LEAD PROJECT 391-NEUROCOG. TESTING

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date: ____

Claimant Signature

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)

	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
★ TAHLEQUAH-MIAMI & VICINITY	03	14	83	17	8:00PM						
MIAMI-PICHER VICINITY-MIAMI	03	15	20	07							
MIAMI-VICINITY-PICHER-MIAMI	03	16	20	13							
MIAMI-VICINITY-TAHLEQUAH	03	17	83	17	0800	~~1600~~ 1700	3	9	$25.00	81.25	~~120.00~~ 120.00
											~~214.79~~ 201.25
★ Lives in Tahlequah, Closer than OKC.											
									SE 00	38 22	
TOTALS			206	54							
			260		TOTAL MILES @ .325				PER MILE =		84.50

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):
SHUTTLE:	TELEPHONE: TOLLS:
RENTAL CAR:	PARKING: TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP. 285.75
	TOTAL AMOUNT CLAIMED ~~299.04~~

I, KAREN CORNELL the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit;

Claimant Signature

RECEIVED

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 3-31 2000

My Commission expires 5-27 2002

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Official

Chief, Financial Management

APR 20 2000

Title

Agency, Bd., or Div. Use ADAIR COUNTY HEALTH DEPT.

PERSONAL IDENTIFIER(S) REDACTED

SUPER 8 MOTEL MIAMI OK #03869
2120 E. STEVE OWENS BLVD
MIAMI, OK 74354
PHONE: (918)542-3382 * FAX:(918)540-0535

KAREN CORNELL
HEALTH DEPT

PERSONAL IDENTIFIER(S) REDACTED

FOLIO. 68011 ROOM. 222 REG#.
ARRIVE 03/14/00
DEPART 03/17/00
TODAY 03/17/00
#GUESTS 1

RATE..39.49
TIME CHECKED IN..11:54 TIME CHECKED OUT..

ROOM #	SH	DATE	CD	DESCRIPTION	AMOUNT	BALANCE
222	A	03/14/00	E	ROOM RENT	39.49	39.49
222	A	03/14/00	F	CITY AND STATE	3.36	42.85
222	A	03/14/00	F	MOTEL TAX	1.58	44.43
222	C	03/15/00	E	ROOM RENT	39.49	83.92
222	C	03/15/00	F	CITY AND STATE	3.36	87.28
222	C	03/15/00	F	MOTEL TAX	1.58	88.86
222	C	03/16/00	E	ROOM RENT	39.49	128.35
222	C	03/16/00	F	CITY AND STATE	3.36	131.71
222	C	03/16/00	F	MOTEL TAX	1.58	133.29
222	A	03/17/00	N	BANK CARD	133.29	0.00

********** TOTAL DUE..... 0.00

ROOM RENT.. 118.47 ROOM TAX... 14.82 VISA/MASTR. 133.29

FINANCIAL MANAGEMENT

TRAVEL CLAIM CORRECTION REQUEST

4881

Personal Health | Cornell | Karen

March | 299.04

Other Remarks & Comments:

Please write on the front of the claim why travel began and ended in Tahlequah instead of official duty station (Stillwell).

Patti Ream | 4/13/00

Date

(OSF FORM 00)

OSF REJECTION NOTICE

This rejection notice MUST BE RETURNED with claim.

AGENCY NO. 340 CLAIM NO. 31879 ORDER NO.

Date 4-24-00 Phone: 521- 6180 Pre-audited by: Cheryl

01 OVERDRAWN	07 FUND	13 PAYEE	19 AGENCY REQUEST	25 CLAIMANT'S INIT.
02 CHANGE ORDER	08 ACCOUNT	14 NOTARY	20 LOCAL PROJECT	26 VENDOR SNAG
03 ENCUMB. REQ'D.	09 SUB-ACTIVITY	15 CALCULATION	21 PER DIEM	27 OTHER
04 APPRVG OFFICER	10 OBJECT CODE	16 FISCAL EXP	22 LODGING	
05 CASH	11 INV SIGNATURE	17 FUNDS LAPSED	23 TRANSPORTATION	** ORDER NUMBER
06 ALLOTMENT	12 INV MISSING	18 FEI#/SS#	24 TRAVEL MISC.	** CLAIM NUMBER

Additional remarks: Please provide documentation indicating the designated hotel from the sponsor in Claim 40 a night.

Agency comments (optional): Returned to Personal Health 4-26

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Please Return With Claim

Reject Number: 4989

Division: Personal Health

Employee: Cornell (Last Name) Karen (First Name) I (MI)

Travel for the Month of: March

Claim Amount: 299.04

Please provide information indicated by check box(es) below.

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel:
- ☐ Verify Funding Information
  - Fund
  - Account
  - Sub-Act
  - Position #
  - Other

Please Complete The Following:

- ☐ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim
- ☐ Agency, Board, or Divisional Use
- ☐ SSN or FEI #
- ☐ License #

TRAVEL

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIPTS

- ☑ Designated Hotel documentation required.
- ☐ Lodging receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt: Statement required on face of claim indicating number of meals included and amount or: "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

MISCELLANEOUS

- ☐ Map Milage Required
- ☐ Amount Exceeds Allotment

Other Remarks & Comments:

Please provide designated hotel information.

Financial Management Reviewed By: Patti Ream

Date: 4/26/00

RECEIVED
2000 APR 27 P 3:28

RECEIVED
APR 26 2000
Personal Health Finance

OSF Form 19
(Revised 1/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
410	340		037516 01

FOR AGENCY USE: BTD AUG 01 02 03 04

MAT Pottawatomie

CLAIM OF: Carol Abbott

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	410	2111	93.200000	232.05
NO X					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					

FOR $232.05 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept of Heal

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

MARK DATE: 06/29/2000

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES X
NO ____

OSF - Audited By:

TOTAL AMOUNT $ 232.05

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Shawnee	Performs nursing services for the Children First Program.

Show point travel status began, each point visited and the point travel status ended (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
~~Shawnee-Vicinity-Return~~	05	01		14							
~~Shawnee-Vicinity-Return~~	05	02		04							
~~Shawnee-Bethel Acres-Shawnee~~	05	02	28								
~~Shawnee-Vicinity-Return~~	05	03		08							
~~Shawno-Prague-Shawnee~~	05	04	52								
~~Shawnee-Tecumseh-Shawnee~~	05	04	14	22							
~~Shawnee-Vicinity-Return~~	05	04		10							
~~Shawnee-Vicinity-Return~~	05	08		19							
~~Shawnee-Bethel Acres-Shawnee~~	05	09	28	04							
~~Shawnee-Vicinity-Return~~	05	10		13							
~~Shawnee-Tecumseh-Shawnee~~	05	10	14	28							
Shawnee-Vicinity-Return	05	11		08	(SEE ADDENDUM)						
TOTALS			384 ✓	330 ✓							
			714		TOTAL MILES @		325		PER MILE =		$232.05 ✓

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI		REGISTRATION FEE (# OF MEALS INCLUDED)		
SHUTTLE		TELEPHONE	TOLLS	
RENTAL CAR		PARKING	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	$232.05 ✓

I, Carol Abbott, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit

Carol Abbott 5/10 10:15
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me _____, 19 ____

My Commission expires _____, 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or _____

Agency's Approving Officer Chief Financial Management

JUN 13 2000
Title Date

Agency, Bd., or Div. Use Pott. Co. Health Dept.
1904 Gordon Cooper Dr.

PERSONAL IDENTIFIER(S) REDACTED

Name Abbott, Carol SSN

Show point travel status began, each point visited, and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity).	Date 2000		Mileage Claimed		Travel Status Hour		No. of		Per Diem		Lodging	Total Per Diem Lodging
	Mo.	Day	Map	Vicinity	Entered	Ended	Days	Hrs.	Rate	Amount	Amount	
Shawnee-McLoud-Shawnee	05	11	28	08								
Shawnee-Vicinity-Return	05	15		09								
Shawnee-McLoud-Shawnee	05	16	28	08								
Shawnee-Vicinity-Return	05	16		09								
Shawnee-BethelAcres-Shawnee	05	16	28									
Shawnee-Vicinity-Return	05	17		19								
Shawnee-Tecumseh-Shawnee	05	17	14	28								
Shawnee-Prague-Shawnee	05	18	52									
Shawnee-Vicinity-Return	05	18		09								
Shawnee-Vicinity-Return	05	22		20								
Shawnee-Vicinity-Return	05	23		04								
Shawnee-BethelAcres-Shawnee	05	23	28	05								
Shawnee-Vicinity-Return	05	24		10								
Shawnee-Tecumseh-Shawnee	05	24	14	28								
Shawnee-Vicinity-Return	05	25		08								
Shawnee-BethelAcres-Shawnee	05	25	28									
Shawnee-Vicinity-Return	05	30		04								
Shawnee-BethelAcres-Shawnee	05	30	28									
Shawnee-Vicinity-Return	05	31		30								
TOTALS												
					TOTAL MILES @					PER MILE =		

ODH 19-1 (10/96)

Name Abbott, Carol SSN PERSONAL IDENTIFIER(S) REDACTED

Show point travel status began, each point visited, and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity).	Date 2000		Mileage Claimed		Travel Status Hour		No. of		Per Diem		Lodging	Total Per Diem Lodging
	Mo.	Day	Map	Vicinity	Entered	Ended	Days	Hrs.	Rate	Amount	Amount	
Shawnee-McLoud-Shawnee	05	11	28	08								
Shawnee-Vicinity-Return	05	15		09								
Shawnee-McLoud-Shawnee	05	16	28	08								
Shawnee-Vicinity-Return	05	16		09								
Shawnee-BethelAcres-Shawnee	05	16	28									
Shawnee-Vicinity-Return	05	17		19								
Shawnee-Tecumseh-Shawnee	05	17	14	28								
Shawnee-Prague-Shawnee	05	18	52									
Shawnee-Vicinity-Return	05	18		09								
Shawnee-Vicinity-Return	05	22		20								
Shawnee-Vicinity-Return	05	23		04								
Shawnee-BethelAcres-Shawnee	05	23	28	06								
Shawnee-Vicinity-Return	05	24		10								
Shawnee-Tecumseh-Shawnee	05	24	14	28								
Shawnee-Vicinity-Return	05	25		08								
Shawnee-BethelAcres-Shawnee	05	25	28									
Shawnee-Vicinity-Return	05	30		04								
Shawnee-BethelAcres-Shawnee	05	30	28									
Shawnee-Vicinity-Return	05	31		30								
TOTALS					TOTAL MILES @					PER MILE =		

ODH 19-1 (10/96)

MT Ottawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		035126pk

FOR AGENCY USE: BTW NW97 011718

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	[illegible]	2111	93.2000000	99.78
NO XX					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____					

OSF - Audited By:

TOTAL AMOUNT $ 99.78

FOR $ 99.78 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of H

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: ____

Claimant Signature

WARR NUM: 8080152
WARR DATE: 05/22/2000
CLAIM NO: 035126

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
Miami-Picher-Vicinity-Miami	3	1	20	4							
Miami-Picher-Vicinity-Miami	3	2	20	15							
Miami-Picher-Vicinity-Miami	3	6	20	48							
Miami-Vicinity-Miami	3	7		4							
Miami-Vinita-Vicinity-Miami	3	13	54	2							
Miami-Picher-Vicinity-Miami	3	15	20	4							
Miami-Picher-Vicinity-Miami	3	16	20	4							
Miami-Vicinity-Miami	3	20		6							
Miami-Picher-Vicinity-Miami	3	28	20	4							
Miami-Picher-Vicinity-Miami	3	30	20	16							
Miami-Vicinity-Miami	3	31		6							
TOTALS			194	113							
			307	307	TOTAL MILES @ 32.5¢				PER MILE =		$99.78

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. ~~$99.78~~

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI	REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE	TELEPHONE	TOLLS
RENTAL CAR	PARKING	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC COSTS	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $99.78

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of ~~Ottawa~~ Oklahoma

Subscribed and sworn before me 5/9/2000

My Commission expires 2/24/2004 19

Cinnamon Wackyle
Notary Public (or Clerk or Judge)

Jane Ann Nichols/bg
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act on 21 15 2000 13

Chief, Financial Management
Agency's Approving Officer

Title

Agency, Bd., or Div. Use

RECEIVED
MAY 18 2000
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19 (Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
410	340		038007 pr

FOR AGENCY USE: BTW NW99 0194B

CLAIM OF: Ottawa Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

WARR NUM: 015703+
WARR DATE: 06/21/2000

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	00035	4200	2111	93.200	239.53
NO XX			2112		110.00
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED			2114		13.50
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?			2115		133.92
YES XX					
NO ____					

OSF - Audited By: TOTAL AMOUNT $496.95

FOR $496.95 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Hea

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami/Ottawa	391 - Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	LODGING
Miami-Wyandotte-Vicinity-Miami	5	1		35								
Miami-Vicinity-Miami	5	3		6								
Miami-Picher-Vicinity-Miami	5	4	20	4								
Miami-Picher-Vicinity-Miami	5	11	20	4								
Miami-Vicinity-Miami	5	12		6								
Miami-Norman-Vicinity-	5	15	208	2	12:30						44.64	$44.64
Norman-Vicinity-	5	16		8			1		25.00	25.00	44.64	$69.64
Norman-Vicinity-	5	17		8			1		25.00	25.00	44.64	$69.64
Norman-Vicinity-	5	18		8			1	3	25.00	25.00		$25.00
Norman-Vicinity-Miami	5	19	208	2		17:30	1	~~4~~	35.00	~~43.75~~*		~~$43.75~~*
Miami-Commerce-Vicinity-Miami	5	22	8	2						35.00		35.00
Miami-Tulsa-Miami	5	25	178									
TOTALS			650	87								~~$252.67~~
			737		737	TOTAL MILES @			32.5¢		PER MILE =	$239.53 ✓

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

*Claiming per diem in lieu of subsistence

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $492.19

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $13.50	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 13.50
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	$492.19
		TOTAL AMOUNT CLAIMED	~~$505.69~~ 496.95

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 6-1, 2000

My Commission expires ____, 19__

Notary Public (or Clerk or Judge)

Jane Ann Nichols / Exp
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Officer

Chief Financial Management

JUN 15 2000

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Form 19 (Rev. 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND: 340

CLAIM NO.:

FOR AGENCY USE:

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES XX
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
OSF - Audited By:			TOTAL AMOUNT $	$

FOR
$
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
_____
Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami/Ottawa	391 - Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Date Day	Mileage Claimed Map	Mileage Claimed Vicinity	Travel Status Hour Entered	Travel Status Hour Ended	No. of Days	No. of Hrs.	Per Diem Rate	Per Diem Amount	Lodging Amount	TOTAL PER DIEM LODGING
Miami-Commerce-Vicinity-Miami	5	30	8	2								
TOTALS												

Page: 1
Date: 5/18/00

NORMAN FAIRFIELD INN
301 NORMAN CENTER CT
NORMAN, OK 73072
405-447-1661

Arrival: 5/15/00
Departure: 5/18/00

Guest Name: WALDORN, SUSAN
Address: PERSONAL IDENTIFIER(S) REDACTED
USA

Mbr. ID:
Level:

Room: 203
Folio Id: 10306 - 2ZX
Plan: FIPD

Date	Description	Reference	Charges	Credits	Balance
5/15/00	Regular Room Charge	Room 203	$40.00	$0.00	$40.00
5/15/00	Occupancy Tax	Room 203	$1.60	$0.00	$41.60
5/15/00	State Tax	Room 203	$3.04	$0.00	$44.64
5/16/00	Regular Room Charge	Room 203	$40.00	$0.00	$84.64
5/16/00	Occupancy Tax	Room 203	$1.60	$0.00	$86.24
5/16/00	State Tax	Room 203	$3.04	$0.00	$89.28
5/17/00	Regular Room Charge	Room 203	$40.00	$0.00	$129.28
5/17/00	Occupancy Tax	Room 203	$1.60	$0.00	$130.88
5/17/00	State Tax	Room 203	$3.04	$0.00	$133.92
5/18/00	American Express	THANK YOU	$0.00	-$133.92	$0.00

Total Folio Page 1 **$0.00**

X _____

Cardholder acknowledges receipt of goods and/or services in the amount of the total shown above and agrees to perform the obligations and terms in the cardholder agreement with the seller.

May 16, 2000

Memorandum

From: Diane Biard–Holmes, Chief,
Human Resources Management Division

Subject: OPHLI Conference

The 2000 Oklahoma Public Health Leadership Institute has been scheduled as follows:

Date and time: May 16, 2000 (8:00 AM to 4:30PM)
May 17, 2000 (8:00 AM to 4:30PM)
May 18, 2000 (8:00 AM to 4:30PM)

Place: OU/DHS Training Center, Norman, OK

Designated Motel: Norman Fairfield Inn
301 Norman Center Court
Norman, OK 73072
Phone/Fax: (405) 447-1661

Room Rate: $40.00 plus $4.64 tax = $44.64

NORMAN FAIRFIELD #167
301 NORMAN CENTER COURT
NORMAN, OK. 73072
405-447-1661

MERCHANT ID: 1301512886095
DATE: 05/18/00 8:06:33 AM

* CHECK OUT *

RECORD NUMBER: 00023
ROOM #: 203
ACCOUNT:
CARD TYPE: AM/EXPRESS
PERSONAL IDENTIFIER(S) REDACTED
CHECK IN DATE: 05/15/00
CHECK OUT DATE: 05/18/00
AUTH CODE: 483135

TRAN TYPE	AUTH CODE	TRAN AMOUNT	TRAN DATE
CKIN	483135	150.00	051800

TOTAL APPROVED: 1 ITEMS : 150.00

FINAL AMOUNT: 133.92

x Susan A. Waldron

I AGREE TO PAY THE ABOVE AMOUNT
ACCORDING TO CARD ISSUER AGREEMENT.
PLEASE IMPRINT CARD

TOP COPY MERCHANT
BOTTOM COPY TO CUSTOMER

MT Ottawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		03243 MT

FOR AGENCY USE: BTD NW91 01249Y

CLAIM OF: ~~Nancy Horton~~

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
01055	42400	2111	93.2000000	84.50
OSF - Audited By:			TOTAL AMOUNT $	84.50

FOR $ 84.50 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Heal

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
_____ Claimant Signature

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Ottawa/Miami	391- Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	TOTAL PER DIEM LODGING
Miami-Afton-Miami	4	4	30									
Miami-Afton-Miami	4	5	30									
Miami-Picher-Vicinity-Miami	4	7	20	4								
Miami-Vicinity-Miami	4	10		8								
Miami-Quapaw-Miami	4	12	20									
Miami-Picher-Vicinity-Miami	4	14	20	4								
Miami-Vicinity-Miami	4	14		8								
Miami-Fairland-Miami	4	18	22									
Miami-Wyandotte-Vicinity-Miami	4	19		35								
Miami-Wyandotte-Vicinity-Miami	4	20		35								
Miami-Vicinity-Miami	4	24		8								
Miami-Vicinity-Miami	4	25		8								
Miami-Commerce-Miami	4	29	8									
TOTALS			150 260	110	260	TOTAL MILES @ 32.5¢				PER MILE =		$84.50

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $84.50

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:		TELEPHONE:	TOLLS:	
RENTAL CAR:		PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	$84.50

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

2000 MAY 10 5 5:01

Nancy C. Horton
Claimant Signature

State of Oklahoma, County of Ottawa

Subscribed and sworn before me 5-1 2000

My Commission expires _____, 19____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel rules and laws of the State.

State Travel Reimbursement Administrator

Agency's Approving Official Chief Financial Management

MAY 12 2000

Title

Agency, Bd., or Div. Use OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

 MT Ottawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
410	340		034236

FOR AGENCY USE: BTCO NW99 01114B

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
800035	4200	2111	93.2000000	162.83
		2114		3.60

OSF - Audited By:

TOTAL AMOUNT $ 166.43

FOR $ 166.43 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Commerce-Vicinity-Miami	4	3	8	2							
**Fairland-Afton-Vicinity-Miami	4	4	33	2							
**Fairland-Afton-Vicinity-Miami	4	5	33	2							
Miami-Picher-Vicinity-Miami	4	7	20	4							
Miami-Vicinity-Miami	4	10		8							
Miami-Vicinity-Miami	4	11		6							
Miami-Quapaw-Vicinity-Miami	4	12	20	6							
Miami-Quapaw-Vicinity-Miami	4	13	20	6							
Miami-Picher-Vicinity-Miami	4	17	20	4							
**Fairland-Vicinity-Mimai	4	18	11	4							
**Fairland-Wyandotte--Vicinity-Miami	4	19		35							
TOTALS			343	158							
			501		501 TOTAL MILES @ 32.5¢				PER MILE =		$162.83

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

*Mileage from home less than mileage from office

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $162.83

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $3.60	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 3.60
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	$162.83
		TOTAL AMOUNT CLAIMED	$166.43

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

RECEIVED

Subscribed and sworn before me 5-2 2000

My Commission expires _____, 19__

Notary Public (or Clerk or Judge)

Jane Ann Nichols / by
Approving Supervisor's Signature KD

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Actor

Agency's Authorized Officer Chief of Financial Management

MAY 1 2 2000

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
	340		

FOR AGENCY USE

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES XX
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT

OSF - Audited By:

TOTAL AMOUNT $

FOR $

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to ____________
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: ____________

Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Date Day	Mileage Claimed Map	Mileage Claimed Vicinity	Travel Status Hour Entered	Travel Status Hour Ended	No. of Days	No. of Hrs.	Per Diem Rate	Per Diem Amount	Lodging Amount	TOTAL PER DIEM LODGING
**Fairland-Wyandotte-Vicinity-Miami	4	20		35								
Miami-Vicinity-Miami	4	21		4								
Miami-Vicinity-Miami	4	24		6								
Miami-Vicinity-Miami	4	25		8								
Miami-Vicinity-Mi[redacted]i	4	26		8								
Miami-Vicinity-Miami	4	27		8								
Miami-Tulsa-Vicinity-Mi[redacted]i	4	28	178	10								

**Mileage from home less than mileage from Office

OSF Form 19
(Revised 1996)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
410	340		033639

FOR AGENCY USE: BTOD NWQ?? 03167

MT Pottawatomie

CLAIM OF: Carol Abbott

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	4200	2111	93.2000000	143.98
NO X					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					

FOR $ 143.98 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of He

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
_____
Claimant Signature

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

OSF - Audited By: TOTAL AMOUNT $ 143.98

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Shawnee	Performs nursing services for the Children First Program.

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Shawnee-Vicinity-Return	04	03		04							
Shawnee-Vicinity-Return	04	05		04							
Shawnee-Tecumseh-Shawnee	04	05	14	22							
Shawnee-Vicinity-Return	04	06		08							
Shawnee-Bethel Acres-Shawnee	04	06	28								
Shawnee-Vicinity-Return	04	10		08							
Shawnee-Vicinity-Return	04	11		04							
Shawnee-Bethel Acres-Shawnee	04	11	28								
Shawnee-Vicinity-Return	04	12		10							
Shawnee-Bethel Acres-Shawnee	04	12	28								
Shawnee-Vicinity-Return	04	13		12							
Shawnee-Prague-Shawnee	04	13	52		(SEE ADDENDUM)						
TOTALS			247	196							
			443		TOTAL MILES @		.325		PER MILE =		$143.98

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:		TELEPHONE:	TOLLS:	
RENTAL CAR:		PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	$143.98

I, Carol Abbott, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is due and wholly unpaid, and that I am duly authorized to make this affidavit.

Carol Abbott 4-28-00
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me _____, 19 ____.

My Commission expires _____, 19 ____. _____
Notary Public (or Clerk or Judge)

RECEIVED
2000 MAY -1 A 10:21

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

_____
Agency Approving Official
Chief, Financial Management

MAY 0 8 2000

Title
Agency, Bd., or Div. Use

Pott. Co. Health Dept.
1904 Gordon Cooper Drive
Shawnee, OK 74801-8538

Approving Supervisor's Signature

Name Abbott, Carol SSN PERSONAL IDENTIFIER(S) REDACTED

Show point travel status began, each point visited, and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity).	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	Total Per Diem Lodging
Shawnee-Vicinity-Return	04	17		04								
Shawnee-Vicinity-Return	04	18		10								
Shawnee-Vicinity-Return	04	19		12								
Shawnee-Vicinity-Return	04	20		08								
Shawnee-Vicinity-Return	04	24		08								
Shawnee-Tecumseh-Shawnee	04	24	14	32								
Shawnee-Vicinity-Return	04	25		14								
Shawnee-BethelAcres-Shawnee	04	25	28									
Shawnee-McLoud-Shawnee	04	25	28	08								
Shawnee-Vicinity-Return	04	26		14								
* Shawnee-McLoud-Bethel Acres	04	27	27	14								
*Home Visit after 5pm. Nurse home closer.												
TOTALS					TOTAL MILES @					PER MILE =		

ODH 19-1 (10/96)

OSF Form 119
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
410	340		031652 al

FOR AGENCY USE: RTOD NWA99 03-DHP

CLAIM OF: Carol Abbott

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	8025	4200	2111	93.200000	191.75
NO X					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	191.75

FOR $ 191.75 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of He

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____

Claimant Signature

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Shawnee	Performs nursing services for the Children First Program.

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Shawnee-Vicinity-Return	03	01		12							
Shawnee-Tecumseh-Shawnee	03	01	14								
Shawnee-Vicinity-Return	03	02		18							
Shawnee-Bethel Acres-Shawnee	03	02	28								
Shawnee-Prague-Shawnee	03	06	52								
Shawnee-McLoud-Shawnee	03	06	28	08							
Shawnee-Vicinity-Return	03	07		04							
Shawnee-Vicinity-Return	03	08		10							
Shawnee-Tecumseh-Shawnee	03	08	14								
Shawnee-Vicinity-Return	03	09		08							
Shawnee-Bethel Acres-Shawnee	03	09	28								
Shawnee-Vicinity-Return	03	10		18	(SEE ADDENDUM)						
TOTALS			398	192							
			590		TOTAL MILES @		.325		PER MILE =		$191.75

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:		TELEPHONE:	TOLLS:	
RENTAL CAR:		PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	$191.75

I, Carol Abbott, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Carol Abbott
Claimant Signature

State of Oklahoma County of Pottawatomie

Subscribed and sworn before me April 3 2000

My Commission Expires March 17 2001

Kathleen Garrett
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Agency's Approving Officer

Chief, Financial Management

Title

APR 20 2000

Date

Agency, Bd., or Div. Use: Pott. Co. Health Dept.
1904 Gordon Cooper Drive

Name Abbott, Carol SSN PERSONAL IDENTIFIER(S) REDACTED

Show point travel status began, each point visited, and the point travel status ended. (Vicinity only travel should show general geographnical area, e.g., Tulsa Vicinity).	Date 2000		Mileage Claimed		Travel Status Hour		No. of		Per Diem		Lodging	Total Per Diem Lodging
	Mo.	Day	Map	Vicinity	Entered	Ended	Days	Hrs.	Rate	Amount	Amount	
Shawnee-Vicinity-Return	03	17		04								
Shawnee-Vicinity-Return	03	21		08								
Shawnee-Prague-Shawnee	03	21	52									
Shawnee-McLoud-Shawnee	03	21	28	08								
Shawnee-Vicinity-Return	03	22		08								
Shawnee-Tecumseh-Shawnee	03	22	14									
Shawnee-Vicinity-Return	03	23		16								
Shawnee-BethelAcres-Shawnee	03	23	28									
Shawnee-BethelAcres-Shawnee	03	23	28									
Shawnee-Vicinity-Return	03	27		14								
Shawnee-McLoud-Shawnee	03	27	28	08								
Shawnee-McLoud-Shawnee	03	28	28	08								
Shawnee-Vicinity-Return	03	28		04								
Shawnee-Vicinity-Return	03	29		14								
Shawnee-BethelAcres-Shawnee	03	29	28									
Shawnee-Vicinity-Return	03	30		22								
TOTALS												
					TOTAL MILES @					PER MILE =		

ODH 19-1 (10/96)

Ottawa pr.

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
465	340		030907

FOR AGENCY USE: BTO NW 99 00494

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
[illegible]	[illegible]	2111	93200-0	70.20

OSF - Audited By:

TOTAL AMOUNT $ 70.20

FOR $ 70.20 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of H

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 7961/96
WARR DATE: 04/10/2000
CLAIM NO: 030907

OFFICIAL DUTY STATION: MIAMI
NATURE OF OFFICIAL BUSINESS: LEAD PROJECT/391

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI-PICHER-MIAMI	03	01	20								
MIAMI-PICHER-MIAMI	03	02	20								
MIAMI-PICHER-MIAMI	03	13	20	10							
MIAMI-PICHER-MIAMI	03	14	20								
MIAMI-PICHER-MIAMI -PICHER-MIAMI	03	15	40								
MIAMI-PICHER-MIAMI-PICHER-MIAMI	03	16	40								
MIAMI-PICHER-MIAMI	03	27	20								
MIAMI-PICHER-MIAMI	03	28	20								
MIAMI VICINITY	03	30		06							
TOTALS			200	16	216	TOTAL MILES @			.326	PER MILE =	70.20

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 70.20

I, NANCY HORTON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 4-4-2000, 19__

My Commission expires 5-27 2002, 19__

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Chief Financial Management
Agency's Approving Officer

Title
Agency, Bd., or Div. Use

RECEIVED
APR 14 2000
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Ottawa Co.

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
422	340		027883

FOR AGENCY USE: BTAD NW97 ~~DD1791~~

CLAIM OF: NANCY C. HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	00035	4200	2111	93.200000	40.30
NO XX					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?			XX		
YES XX					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	40.30

FOR $ 40.30 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. o

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
_____
Claimant Signature

WARR DATE: 03\21\2000 WARR NUM: 7867810 CLAIM NO: 027883

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391-LEAD GRANT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Picher-Miami	02	3	20								
Miami-Vicinity-Miami	02	7		6							
Miami-Commerce-Miami	02	9	8								
Miami-Vicinity-Miami	02	9		6							
Miami-Vicinity-Miami	02	10		8							
Miami-Vicinity-Miami	02	11		4							
Miami-Quapaw-Miami	02	17	20								
Miami-Vicinity-Miami	02	25		8							
Miami-Fairland-Miami	02	29	22								
Miami-Vicinity-Miami	02	29		8							
Miami-Cardin-Miami	02	29	14								
TOTALS			84	40							
			124		124	TOTAL MILES @ 32.5¢			PER MILE =		$40.30

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:		TELEPHONE:	TOLLS:	
RENTAL CAR:		PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	$40.30

I, NANCY HORTON, the undersigned, upon oath do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid. And that I am duly authorized to make this affidavit.

2000 MAR 13 A 11:3d

Nancy Horton

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 03-02 2000

My Commission expires 05-27 2000

Janice Lynn
Notary Public (or Clerk or Judge)

Jane Ann Nichols
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or

Chief, Financial Management
Agency's Approving Officer

MAR 17 2000

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
Title
Agency, Bd., or Div. MIAMI, OKLAHOMA 74354

Ottawa Co

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		027885

FOR AGENCY USE: BTOD NW97 C1174B

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
[illegible]	42000	2111	93.2000000	91.00

OSF - Audited By:

TOTAL AMOUNT $ 91.00

FOR $ 91.00 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7867812
WARR DATE: 03\21\2000
CLAIM NO: 027885

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391 - LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Picher-Vicinity-Miami	02	03	20	4							
Miami-Vinita-Miami	02	04	54								
Miami-Commerce-Vic.-Miami	02	14	8	8							
Miami-Picher-Vicinity-Miami	02	15	20	6							
Miami-Commerce-Vic.-Miami	02	16	8	2							
Miami-Picher-Vicinity-Miami	02	17	20	10							
Miami-Vicinity-Miami	02	22		6							
Miami-Commerce-Vic.-Miami (x2)	02	23	16	4							
Miami-Commerce-Vic.-Miami (x2)	02	24	16	4							
Miami-Picher-Vicinity-Miami	02	25	20	15							
Miami-Commerce-Vic.-Miami	02	28	8	2							
Miami-Picher-Vicinity-Miami	02	29	20	9							
TOTALS			210	70							
			280		280 TOTAL MILES @ 32.5¢ PER MILE -						$91.00

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $91.00

I, SUSAN WALDRON, [illegible] assigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 03-02 2000

My Commission expires 05-27 2000

Janice Lynn
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

RECEIVED
MAR 13 A 11:38

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Officer

Chief, Financial Management
MAR 17 2000

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		026630pr

FOR AGENCY USE: BTCO NW99 004985

CLAIM OF: Adair pr
KAREN K. CORNELL
S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	4200	2111	93174-0	68.25
		2112		56.25
		2114		3.45
		2115		80.00

OSF - Audited By:
TOTAL AMOUNT $ 207.95

FOR $207.95 AGAINST
Agency, Board, Comm., Dept.: Okla. State Dept. of H

ASSIGNMENT
I hereby assign this claim to
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date:
Claimant Signature

WARR DATE: 03/09/2000
WARR NUM: 7827853
CLAIM NO: 026630

OFFICIAL DUTY STATION: STILLWELL
NATURE OF OFFICIAL BUSINESS: 391 LEAD PROJECT -LEAD POISONING PREVENTION PROGRAM

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	
STILLWELL-MIAMI-VICINITY	02	03	95	20	9:00AM							
MIAMI VICINITY	02	04		12							80.00	136.25
U MIAMI- TAHLEQUAH	02	05	83			5:00PM	2	8	25.	56.25	~~88.86~~	~~145.36~~
Lives in Tahlequah, closer than duty station												
TOTALS			178	32								136.25 ~~145.36~~
				210	TOTAL MILES @			325		PER MILE =		68.25

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS:	3.45
RENTAL CAR:	PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	~~217.06~~ 207.95

I, KAREN K. CORNELL, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Karen Cornell
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 2-9, 19 2000

My Commission expires 5-27, 19 2002

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Chief, Financial Management
Agency's Approving Officer

MAR 07 2000

Title
Agency, Bd., or Div. Use
ADAIR CO. HEALTH DEPT.
600 W. HICKORY
STILLWELL, OK 74950

SUPER 8 MOTEL MIAMI OK #03869
2120 E. STEVE OWENS BLVD
MIAMI, OK 74354
PHONE: (918)542-3382 * FAX:(918)540-0535

KAREN CORNELL
HEALTH DEPT

PERSONAL IDENTIFIER(S) REDACTED

FOLIO. 66211 ROOM. 221 REG#.
ARRIVE 02/02/00
DEPART 02/04/00
TODAY 02/04/00
#GUESTS 1

RATE..39.49
TIME CHECKED IN..17:20 TIME CHECKED OUT..

ROOM #	SH	DATE	CD	DESCRIPTION	AMOUNT	BALANCE
221	B	02/02/00	E	ROOM RENT	39.49	39.49
221	B	02/02/00	F	CITY AND STATE	3.36	42.85
221	B	02/02/00	F	MOTEL TAX	1.58	44.43
221	C	02/03/00	E	ROOM RENT	39.49	83.92
221	C	02/03/00	F	CITY AND STATE	3.36	87.28
221	C	02/03/00	F	MOTEL TAX	1.58	88.86
221	A	02/04/00	N	BANK CARD	88.86	0.00

********** TOTAL DUE..... 0.00

ROOM RENT.. 78.98 ROOM TAX... 9.88 VISA/MASTR. 88.86

DATE 40570000[illegible] TIME
02/04/00 0000000000 07:49

SUPER 5 MIAMI
[illegible] EAST STEVE OWENS BLVD
MIAMI, OK 74354
918-542-3362

TRAN # AUTH
936 [illegible]
REENTRY CALF

ACCT. NUMBER EXP

PERSONAL IDENTIFIER(S) REDACTED

POLIO # CHG TYPE

TOTAL $ 58.66

SIGNATURE [illegible]

THANK YOU

TOP COPY-MERCHANT
BOTTOM COPY-CUSTOMER

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Reject Number: 4639

Please Return With Claim

Division: Personal Health Employee: Cornell (Last Name) Karen (First Name) K (MI)

Travel for the Month of: February Claim Amount: 207.95

Please provide information indicated by check box(es) below.

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel:
- ☐ Verify Funding Information
  - Fund [redacted]
  - Account [redacted]
  - Sub-Act [redacted]
  - Position # [redacted]
  - Other [redacted]

Please Complete The Following:

- ☐ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim
- ☐ Agency, Board, or Divisional Use
- ☐ SSN or FEI #
- ☐ License #

TRAVEL

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIVED
MAR 0 6 2000
FINANCIAL MANAGEMENT UNIT

RECEIPTS

- ☐ Designated Hotel documentation required.
- ☐ Lodging receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt: Statement required on face of claim indicating number of meals included and amount or: "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

RECEIVED
FEB 2 2 2000
Personal Health Finance

MISCELLANEOUS

- ☐ Map Milage Required
- ☐ Amount Exceeds Allotment

RECEIVED
MAR 0 9 2000
Personal Health Finance

Other Remarks & Comments:

Please write on the front of the claim why travel ended in Tahlequah instead of official duty station.

Financial Management Reviewed By: Patti Ream Date: 2/18/00

Ottawa PR

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
1[illegible]	340		025100

FOR AGENCY USE [illegible]

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	[illegible]	2111	93174000	25.03
NO XX					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____	OSF - Audited By:			TOTAL AMOUNT	$25.03

FOR
$ 25.03
AGAINST
Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 7788200
WARR DATE: 02/28/2000
CLAIM NO: 025100

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI VICINITY	1	19		6							
MIAMI TO COMMERCE TO MIAMI	1	20	8	4							
MIAMI TO PICHER TO QUAPAW TO FAIRLAND TO MIAMI VIC	1	21	42	17							
TOTALS			50	27							
			77		TOTAL MILES @ 32.5¢				PER MILE =		25.03

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 25.03

I, NANCY HORTON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 2-22-2000

My Commission expires 5-21-2002 Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or

[illegible], Financial Manager FEB 22 2000

Agency's Approving Officer

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
Title MIAMI, OKLAHOMA 74354
Agency, Bd., or Division

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Please Return With Claim

Reject Number: 4616

Division: Personal Health

Employee: Horton (Last Name) Nancy (First Name) (MI)

Travel for the Month of: January

Claim Amount: 25.03

Please provide information indicated by check box(es) below.

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel:
- ☐ Verify Funding Information
  - Fund [redacted]
  - Account [redacted]
  - Sub-Act [redacted]
  - Position # [redacted]
  - Other [redacted]

Please Complete The Following:

- ☑ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim
- ☐ Agency, Board, or Divisional Use
- ☐ SSN or FEI #
- ☐ License #

RECEIVED
FEB 17 REC'D
FINANCIAL MANAGEMENT

TRAVEL

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIVED
FEB 15 2000
Personal Health Finance

RECEIPTS

- ☐ Designated Hotel documentation required.
- ☐ Lodging receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt: Statement required on face of claim indicating number of meals included and amount or: "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

MISCELLANEOUS

- ☐ Map Milage Required
- ☐ Amount Exceeds Allotment

Other Remarks & Comments:

Please provide a more detailed explanation of what duties were performed in the nature of official business block.

OK - MS

Financial Management Reviewed By: Patti Ream

Date: 2/14/00

Oklawn pr...

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
1 1	340		025098 pr

FOR AGENCY USE

CLAIM OF: JENNIFER BUSHERS

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____			2111	93174000	20.15
NO XX					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____	OSF - Audited By:			TOTAL AMOUNT $	20.15

FOR $ 20.15
AGAINST
Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 7788196
WARR DATE: 02/24/2000
CLAIM NO: 025098

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
MIAMI VICINITY	1	3		5							
MIAMI VICINITY	1	4		5							
MIAMI TO PICHER TO MIAMI	1	6	20	6							
MIAMI VICINITY	1	18		5							
MIAMI VICINITY	1	20		3							
MIAMI VICINITY	1	21		5							
MIAMI VICINITY	1	25		7							
MIAMI VICINITY	1	27		3							
MIAMI VICINITY	1	28		3							
TOTALS			20	42							
				62	TOTAL MILES @	32.5¢	PER MILE =				20.15

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS	
TAXI		REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE		TELEPHONE	TOLLS
RENTAL CAR		PARKING	TOTAL MISC
OTHER LOCAL TRANSP.		OTHER MISC. COSTS	TOTAL LOCAL TRANSP.
			TOTAL AMOUNT CLAIMED 20.15

I, JENNIFER BUSHERS the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit

Jennifer Bushers
Claimant Signature

State of Oklahoma County of OTTAWA

Subscribed and sworn before me 2-22 19 00

My Commission expires 5-21 19 00 Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Unit
Chief, Financial Management

FEB 22 2000

Agency's Approving Officer

Title

Agency, Bd., or Div. Title

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Please Return With Claim

Reject Number: 4615

Division: Personal Health

Employee: Bushers (Last Name) Jennifer (First Name) MI

Travel for the Month of: January

Claim Amount: 20.15

Please provide information indicated by check box(es) below.

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel:
- ☐ Verify Funding Information
  - Fund [redacted]
  - Account [redacted]
  - Sub-Act [redacted]
  - Position # [redacted]
  - Other [redacted]

Please Complete The Following:

- ☑ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim
- ☐ Agency, Board, or Divisional Use
- ☐ SSN or FEI #
- ☐ License #

RECEIVED
FEB 17 RECD
FINANCIAL MANAGEMENT

TRAVEL

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIVED
FEB 15 2000
Personal Health Finance

RECEIPTS

- ☐ Designated Hotel documentation required.
- ☐ Lodging receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt: Statement required on face of claim indicating number of meals included and amount or: "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

MISCELLANEOUS

- ☐ Map Milage Required
- ☐ Amount Exceeds Allotment

Other Remarks & Comments:

Please provide a more detailed explanation of what duties were performed in the nature of official business block.

DH - MS

Financial Management Reviewed By: Patti Ream

2/14/00
Date:

Ottawa pp

OSI Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
[illegible]	340		025097

FOR AGENCY USE: [illegible]

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
[illegible]	[illegible]	2111	93174000	51.35

OSF - Audited By:

TOTAL AMOUNT $ 51.35

FOR $ 51.35 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7788197
WARR DATE: 02/28/2000
CLAIM NO: 025097

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
MIAMI TO COMMERCE TO MIAMI	1	4	8	2							
MIAMI TO PICHER TO MIAMI	1	6	20	4							
MIAMI TO COMMERCE TO MIAMI	1	11	8	2							
MIAMI VICINITY	1	12		8							
MIAMI TO COMMERCE TO MIAMI	1	18	8	2							
MIAMI TO PICHER TO MIAMI	1	19	20	2							
MIAMI TO COMMERCE TO MIAMI	1	20	8	2							
MIAMI TO COMMERCE TO MIAMI	1	24	8	2							
MIAMI TO PICHER TO MIAMI	1	25	20	6							
MIAMI VICINITY	1	26		6							
MIAMI TO QUAPAW TO MIAMI	1	27	20	2							
TOTALS			120	38							
			158		TOTAL MILES @ 32.5				PER MILE =		51.35

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS	
TAXI	[illegible]	REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE		TELEPHONE	TOLLS
RENTAL CAR		PARKING	TOTAL MISC
OTHER LOCAL TRANSP.		OTHER MISC COSTS	TOTAL LOCAL TRANSP.
			TOTAL AMOUNT CLAIMED 51.35

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 2-2-2000

My Commission expires 5-21-2002

[illegible]
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act of

Gayle Cox
Chief, Financial Management

Agency's Approving Officer

FEB 22 2000
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Title

Agency, Bd., or Div. Use

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Please Return With Claim

Reject Number: 4614

Division: Personal Health Employee: Waldron (Last Name) Susan (First Name) MI

Travel for the Month of: January Claim Amount: 51.35

Please provide information indicated by check box(es) below.

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel:
- ☐ Verify Funding Information
  - Fund [redacted]
  - Account [redacted]
  - Sub-Act [redacted]
  - Position # [redacted]
  - Other [redacted]

Please Complete The Following:

- ☑ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim
- ☐ Agency, Board, or Divisional Use
- ☐ SSN or FEI #
- ☐ License #

TRAVEL

RECEIVED
FEB 17 RECD
FINANCIAL MANAGEMENT

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIPTS

RECEIVED
FEB 15 2000
Personal Health Finance

- ☐ Designated Hotel documentation required.
- ☐ Lodging receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt: Statement required on face of claim indicating number of meals included and amount or: "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

MISCELLANEOUS

- [ ] Map Milage Required
- [ ] Amount Exceeds Allotment

Other Remarks & Comments:

Please provide a more detailed explanation of what duties were performed in the nature of official business block.

OK MS

Financial Management Reviewed By: Patti Ream 2/14/00 (Date)

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
1100	340		021193

FOR AGENCY USE: Ottawa pe

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____ NO XX	[illegible]	[illegible]	2111	93.1740000	73.78
LICENSE NO. PERSONAL IDENTIFIER REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	73.78

FOR $ 73.78
AGAINST
Agency, Board, Comm., Dept.: Okla. State Dep

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to i warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR DATE: 01/19/2000
WARR NUM: 7051875
CLAIM NO: 021193

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami, OK	391/Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)

Date 1999 Mo	Date 1999 Day	Mileage Claimed Map	Mileage Claimed Vicinity	Travel Status Hour Entered	Travel Status Hour Ended	No. of Days	No. of Hrs	Per Diem Rate	Per Diem Amount	Lodgi Amo
Miami-Picher-Miami	12 02	20	26							
Miami-Vicinity	03		4							
Miami-Picher-Miami	09	20								
Miami-Vicinity	10		4							
Miami-Picher-Miami	15	20	26							
Miami-Commerce-Miami	16	8	2							
Miami-Commerce-Miami	20	8	2							
Miami-Picher-Miami	28	20	26							
Miami-Picher-Miami	29	20	26							
Miami-Vicinity	30		6							
TOTALS		116	122	238 TOTAL MILES @			.31	PER MILE =		73.78

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS	
TAXI		REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE		TELEPHONE / TOLLS	
RENTAL CAR		PARKING	TOTAL MISC
OTHER LOCAL TRANSP.		OTHER MISC. COSTS	TOTAL LOCAL TRANSP.
			TOTAL AMOUNT CLAIMED 73.78

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 01-03-2000

My Commission expires 5-27-2002 James Linn
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

Agency's Approving Official

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Title Date

Agency, Bd., or Div. Use

Ottawa pr

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
410	340	-	021188

FOR AGENCY USE: BLED NUCFC 6/28/21

CLAIM OF: JENNIFER I. BUSHERS

S.S. No.: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	[illegible]	2111	93.1740000	57.04
NO XX					
LICENSE NO.					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT	$57.04

FOR $ 57.04 AGAINST

Agency, Board, Comm., Dept.: Okla State Dept.

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR DATE: 01/19/2000
WARR NUM: 765287
CLAIM NO: 021188

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	CLERICAL DUTIES, LEAD PREVENTION PROGRAM.

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1999 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodgi Amo
MIAMI VICINITY	12	1		3							
MIAMI VICINITY	12	3		3							
MIAMI VICINITY	12	8		3							
MIAMI VICINITY	12	15		3							
MIAMI VICINITY	12	16		3							
MIAMI TO QUAPAW TO MIAMI VIC.	12	17	20	2							
MIAMI VICINITY	12	20		3							
MIAMI TO QUAPAW TO MIAMI VIC.	12	21	20	2							
MIAMI VICINITY	12	22		3							
MIAMI VICINITY	12	23		3							
MIAMI TO PICHER VIC. TO MIAMI	12	28	20	38							
MIAMI TO PICHER VIC. TO MIAMI	12	29	20	38							
TOTALS			80	108							
			~~183~~	184	TOTAL MILES @ .31¢				PER MILE =		56.73

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED: 57.04

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI		REGISTRATION FEE (# OF MEALS INCLUDED)		
SHUTTLE		TELEPHONE	TOLLS	
RENTAL CAR		PARKING	TOTAL MISC	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	56.73

57.04

I, Jennifer I. Bushers, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Jennifer I. Bushers
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 12-29-1999

My Commission expires 5-27-19[illegible]

Jamie Lynn
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

RECEIVED

State Travel Reimbursement Act or

JAN 19 2000

Agency's Approving Officer

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
Title
Agency, Bd., or Div. MIAMI, OKLAHOMA 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
1 1	340		211.2

FOR AGENCY USE: B.U. NEPA QUAPAW

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	[illegible]	2111	93.20000	28.83
NO X					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____	OSF - Audited By:			TOTAL AMOUNT	$ 28.83

FOR $ 28.83
AGAINST
Agency, Board, Comm., Dept.: Okla. State Dept. of He

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____

Claimant Signature

WARR NUM: 7047??
WARR DATE: 01/18/2000
CLAIM NO: 221121

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391/LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1999 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
MIAMI-COMMERCE-MIAMI	11	29	08								
MIAMI-QUAPAW-MIAMI	12	03	20								
MIAMI VICINITY	12	06		03							
MIAMI-COMMERCE-MIAMI	12	07	08								
MIAMI VICINITY	12	08		06							
MIAMI-FAIRLAND-MIAMI	12	09	22								
MIAMI-PICHER-QUAPAW-MIAMI	12	13	20	06							
TOTALS			78	15							
			93		TOTAL MILES @	.31			PER MILE =		28.83

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS	
TAXI		REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE		TELEPHONE	TOLL [illegible]
RENTAL CAR		PARKING	TOTAL MISC
OTHER LOCAL TRANSP.		OTHER MISC COSTS	TOTAL LOCAL TRANSP.
			TOTAL AMOUNT CLAIMED 28.83

I, NANCY HORTON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit

Nancy L. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 12-13 19 99

My Commission expires 5-27 19 2002

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim and certify it complies with the travel laws of the State [illegible] State Travel Reimbursement Act or [illegible]

JAN 18 2000

Agency's Approving Officer

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
Agency, Bd., or Div MIAMI, OKLAHOMA 74354

Title

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		019166

FOR AGENCY USE: 12-16-99
BT00 NW97 00669P

CLAIM OF: NANCY HORTON, RN

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ___	00003.5	42000	2111	93.2000000	62.93
NO X			2123		110.50
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED			2126		269.68
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?			2124		21.00
YES X					
NO ___					

OSF - Audited By:

TOTAL AMOUNT $ 464.11

FOR $ 464.11 AGAINST

Agency, Board, Comm., Dept.: Okla State Dept. of He

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: NATIONAL LEAD TRAINING / 391/LEAD PROJECT LOUISVILLE, KY

WARR NUM: 7588503
WARR DATE: 12\29\1999
CLAIM NO: 019166

Show point travel status began, each point visited and the point travel status ended (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1999 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount	
MIAMI-PICHER-MIAMI	10	27	20	05								
MIAMI-TULSA ** - [illegible]	11	14	89		1400							
TULSA-MIAMI	11	18	89			2100	4	7	26	110.50	269.68	380.18
AIRLINE TRANSPORTATION PAID BY OSDH PURCHASE ORDER- (ITINERARY ATTACHED)												
TOTALS			198	05								
				203	TOTAL MILES @ .31						PER MILE =	62.93

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE X (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS	
TAXI		REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE		TELEPHONE	TOLLS
RENTAL CAR		PARKING	TOTAL MISC. ~~23.10~~ 21
OTHER LOCAL TRANSP.		OTHER MISC COSTS TAXI 21.00	TOTAL LOCAL TRANSP.
			TOTAL AMOUNT CLAIMED ~~466.21~~ 464.11

I, NANCY HORTON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 11-29-99, 19

My Commission expires 5-27, 2002

Janice Lewis
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or

Agency's Approving Officer

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

T[illegible] Inn
at J[illegible] Hospital

100 East Jefferson Street
Louisville, KY 40202
502-582-2481
502-582-3511(fax)

Name: HORTON, NANCY	Room: 312	Rate: $60.00	Nights: 5	Folio: 2040
Add[illegible]	Arrival Date: 11/14/1999		Departure Date: 11/19/1999	
Add[illegible] PERSONAL IDENTIFIER(S) REDACTED	Group ID: NAT		Corp ID:	
City: PERSONAL IDENTIFIER(S) REDACTED	Company:			
State: OK	Group:			
Postal: PERSONAL IDENTIFIER(S) REDACTED	Adults: 1	Children: 0		
Phone: PERSONAL IDENTIFIER(S) REDACTED	Date/Time: 11/18/1999 2:17:46 PM			
Signature:	Comments:			

DATE	DESCRIPTION	CHARGE	CREDIT	BALANCE
11/1[illegible]9	Room Room 312	$60.00	$0.00	$60.00
11/1[illegible]9	Local Occupancy Tax	$3.60	$0.00	$63.60
11/1[illegible]9	Room Room 312	$60.00	$0.00	$123.60
11/1[illegible]9	Local Occupancy Tax	$3.60	$0.00	$127.20
11/1[illegible]9	KY Sales Tax Sales Tax 11/14	$3.82	$0.00	$131.02
11/1[illegible]99	KY Sales Tax Sales Tax 11/15	$3.82	$0.00	$134.84
11/1[illegible]9	Room Room 312	$60.00	$0.00	$194.84
11/1[illegible]9	KY Sales Tax	$3.82	$0.00	$198.66
11/1[illegible]9	Local Occupancy Tax	$3.60	$0.00	$202.26
11/1[illegible]9	Room Room 312	$60.00	$0.00	$262.26
11/1[illegible]9	KY Sales Tax	$3.82	$0.00	$266.08
11/1[illegible]9	Local Occupancy Tax	$3.60	$0.00	$269.68
11/1[illegible]	PERSONAL IDENTIFIER(S) REDACTED	$0.00	$269.68	$0.00
	09/02			
	TOTAL DUE			$0.00

I certify this as a true & correct copy of the original. Original was lost. C. Walker 12/2/99

WEDNESDAY, November 17

8:00 A.M. - 8:15 A.M.	*COFFEE AND ANNOUNCEMENTS*
8:15 - 9:00	*LEAD SCREENING* How to develop a screening recommendation and current issues. *Paula Staley, RN, BSPH*
9:00 - 9:15	*BREAK*
9:15 - 10:45	*LEAD ABATEMENT TECHNIQUES* Discussion of various recommended techniques and creative responses to problems associated with lead abatement. *David Chambers*
10:45- 11:00	*BREAK*
11:00 - 12:00	*USING A GEOGRAPHIC INFORMATION SYSTEM (GIS)* How Geographic Information System data analyses can be used to aid in resource allocation, and program evaluation. *Forrest Staley, BA, BS* *Neal Rosenblatt, BA, MS*
12:00 - 1:00 P.M.	*LUNCH*
1:00 - 2:30	*COALITION BUILDING* Building community coalitions. *Charyn Sutton*
2:30 - 2:45	*BREAK*
2:45 - 3:45	*SHOW AND TELL* Workshop participants have an opportunity to discuss their programs and share information on effective strategies and materials.
3:45 - 4:45	*GROUP ENVIRONMENTAL SITE VISIT* XRF demonstration.
3:45 - 4:45	*NURSING SITE VISIT*

Mike email for Billie Barton

Katy Soper Data Base

Sed Coupon by Milk?

Stellar? Survey? Lead 101 - Hospital teaching

Reporting of all Blood Lead Levels?

TAXI RECEIPT

AMOUNT 700

DATE 11-18-99

FROM Hotel

TO Airport

DRIVER

TAXI# 624

TAXI RECEIPT

AMOUNT $14.00

DATE 11-14-99

FROM Airport

TO Hotel

DRIVER

TAXI# 580

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: [illegible] ITINERARY/INVOICE NO. [illegible] DATE: [illegible]
CUSTOMER NBR: [illegible] R/VJTY PAGE: 01

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. [illegible]
DEVR TO RUBY SHERWIN 3RD FLOOR TRAVEL DIVISION
TKT ORDERED BY [illegible]
PURCHASE ORDER NUMBER [illegible]

FOR: HORTON NANCY REF: **PERSONAL IDENTIFIER(S) REDACTED**

14 NOV 99 SUNDAY

AIR	TRANS WORLD AIRLINES FLT:[illegible]	COACH	
	LV TULSA	430P	EQP: BOEING 727-200
			01HR 20MIN
	AR ST LOUIS INTL	[illegible]	NON STOP
	ARRIVE: MAIN TERMINAL		REF: 4FLS[illegible]
	HORTON/NANCY SEAT 14B		
AIR	TRANS WORLD AIRLINES FLT:748	COACH	
	LV ST LOUIS INTL	[illegible]	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 14MIN
	AR LOUISVILLE	[illegible]	NON STOP
			REF: 4FLS[illegible]
	HORTON/NANCY SEAT [illegible]		

18 NOV 99 THURSDAY

AIR	TRANS WORLD AIRLINES FLT:[illegible]	COACH	
	LV LOUISVILLE	400P	EQP: MD-80
			01HR 12MIN
	AR ST LOUIS INTL	[illegible]	NON-STOP
	ARRIVE: MAIN TERMINAL		REF: 4FLS[illegible]
	HORTON/NANCY SEAT [illegible]		
AIR	TRANS WORLD AIRLINES FLT:[illegible]	COACH	
	LV ST LOUIS INTL	515P	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 28MIN
	AR TULSA	[illegible]	NON-STOP
			REF: 4FLS[illegible]
	HORTON/NANCY SEAT [illegible]		

AIR TICKET	[illegible]	HORTON NANCY	[illegible]
		SUB TOTAL	[illegible]
		TOTAL AMOUNT DUE	[illegible]

PAYMENT IS DUE UPON RECEIPT OF INVOICE

AG-93

Dec 258

DUE 282.42

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS.

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
410	340		017/1999

FOR AGENCY USE: BTAD NWOT OKLAB

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	[illegible]	2111	93.174000	197.78
NO X	↓	↓	2114	↓	11.00
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					208.78
NO ____	OSF - Audited By:			TOTAL AMOUNT $ [redacted]	

FOR $ 208.78
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Heal

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARK NM: 751514
WARK IT: 12/15/1999
CLAIM NO: 017149

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI/[redacted]	391/ LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)

	Date 1999 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Wyandotte-Vicinity-Miami	11	2	30	2							
Miami-Vicinity-Miami	11	3		6							
Miami-Picher-Vicinity-Miami	11	4	20	2							
Miami-Okla City-Vicinity-Miami	11	5	384	8							
Miami-Commerce-Miami	11	8	8								
Miami-Jay-Vicinity-Miami	11	15	72	4							
Miami-Quapaw-Vicinity-Miami	11	16	20	2							
Miami-Afton-Miami	11	17	30								
Miami-Vicinity-Miami	11	22		4							
Miami-Quapaw-Vicinity-Miami	11	23	20	2							
Miami-Vicinity-Miami	11	24		6							
Miami-Commerce-Vicinity-Miami	11	29	8	2							
Miami-Vicinity-Miami	11	30		8							
TOTALS			[redacted]	46	638						

638 TOTAL MILES @ .31¢ PER MILE = $197.78

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $197.78

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS: $11.00	
RENTAL CAR:	PARKING:	TOTAL MISC. $ 11.00
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP. $197.78
		TOTAL AMOUNT CLAIMED $208.78

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 11-30 1999

My Commission expires 5-27 2002

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

DEC 10 1999
Agency's Approving Officer

OTTAWA COUNTY HEALTH DEPT.
Title
1930 NORTH ELM
Agency, Bd., or Div. Use MIAMI, OKLAHOMA 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDI	NO.
400	340		1u 145

FOR AGENCY USE: BT80 NW99 028634

CLAIM OF: Ottawa Ppe
JENNIFER I. BUSHERS
S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ___ NO X
LICENSE NO.
PERSONAL IDENTIFIER(S) REDACTED
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00085	42080	2111	93.1740000	11.47

OSF - Audited By:
TOTAL AMOUNT $ 11.47

FOR $ 11.47 AGAINST
Agency, Board, Comm., Dept.: Okla. State Dept. of H

WARR NUM: 7551311
WARR DATE: 12/15/1999
CLAIM NO: 017145

ASSIGNMENT
I hereby assign this claim to
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date:
Claimant Signature

OFFICIAL DUTY STATION: MIAMI
NATURE OF OFFICIAL BUSINESS: ADMINISTRATIVE TECH. DUTIES 391/LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1999 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI VINCINITY	11	2		3							
MIAMI VINCINITY	11	3		3							
MIAMI VINCINITY	11	4		3							
MIAMI VINCINITY	11	10		3							
MIAMI VINCINITY	11	12		22							
MIAMI VINCINITY	11	19		3							
TOTALS				37							
				37	TOTAL MILES @ .31¢				PER MILE =		11.47

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 11.47

I, JENNIFER I. BUSHERS, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Jennifer Bushers
Claimant Signature

State of OKLAHOMA County of OTTAWA
Subscribed and sworn before me 12-1, 1999
My Commission expires 5-27 2002
Janice Lenn
Notary Public (or Clerk or Judge)

Jane Ann Nichols
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

DEC 10 1999
Agency's Approving Officer
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354
Title
Agency, Bd., or Div. Use

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T002360	014056

FOR AGENCY USE
WARRANT # 7461364 DATE: 11/18/1999

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	2211	000000000	282.42

CLAIM OF:
TRAVEL AGENTS INC.
731270787

0
1
4
0
5
6

FOR
$ 282.42

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	282.42
054		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/09/1999	37770	282.42

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 221110088X 282.42

J/E XREF:

VENDOR: TRAVEL AGENTS INC.
ADDRESS: 9415 NORTH MAY
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73120

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/15/1999

Title Date

Agency, Bd or Div. Use

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: 33 ITINERARY/INVOICE NO. 0032770 DATE: 09 NOV 99
CUSTOMER NBR: 012057 RZVJYY PAGE: 01

01405

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO RUBY SHERWIN 3RD FLOOR TRAVEL DIVSION
TKT ORDERED BY BETTY
PURCHASE ORDER NUMBER T0023408B 054

FOR: HORTON/NANCY REF:

PERSONAL IDENTIFIER(S) REDACTED

14 NOV 99 -- SUNDAY

AIR	TRANS WORLD AIRLINES FLT:497	COACH	
	LV TULSA	430P	EQP: BOEING 727-200
			01HR 23MIN
	AR ST LOUIS INTL	553P	NON-STOP
	ARRIVE: MAIN TERMINAL		REF: 4FLS32
	HORTON/NANCY SEAT-14B		
AIR	TRANS WORLD AIRLINES FLT:248	COACH	
	LV ST LOUIS INTL	655P	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 14MIN
	AR LOUISVILLE	909P	NON-STOP
			REF: 4FLS32
	HORTON/NANCY SEAT-32F		

18 NOV 99 -- THURSDAY

AIR	TRANS WORLD AIRLINES FLT:561	COACH	
	LV LOUISVILLE	400P	EQP: MD-80
			01HR 12MIN
	AR ST LOUIS INTL	512P	NON-STOP
	ARRIVE: MAIN TERMINAL		REF: 4FLS32
	HORTON/NANCY SEAT-27F		
AIR	TRANS WORLD AIRLINES FLT:713	COACH	
	LV ST LOUIS INTL	615P	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 28MIN
	AR TULSA	643P	NON-STOP
			REF: 4FLS32
	HORTON/NANCY SEAT-32F		

AIR TICKET	TW:6823883571	HORTON NANCY	265.00
		SUB TOTAL	265.00
		TOTAL AMOUNT DUE	265.00
		DSCT	2.58
		DUE	282.42

PAYMENT IS DUE UPON RECEIPT OF INVOICE

AG: 33

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS.

RECEIVED
NOV 08 1999
Public Health Finance

PO T002360

BB

OKLAHOMA STATE DEPARTMENT OF HEALTH

INTERSTATE TRAVEL REQUEST/AUTHORIZATION

PERSONAL IDENTIFIER(S) REDACTED
221110088X

Control No. _____

Date 11-9-99

Budget Code _____

Betty 4727

Nancy Horton - Louisville, Ky - 222 92.2000000

DIVISION: MCH/ Childhood Blood Lead Poisoning Prevention Program

TO BE CHARGED TO: ATSDR Grant (Fund & Account) _____ % (State) _____ % (Federal)

PERSONAL IDENTIFIER(S) REDACTED

APPLICANT: Nancy C. Horton **POSITION (Title):** PHN/Program Grant Consultant Ottawa Co. 00669P

DATE OF DEPARTURE: November 14, 1999

NATURE OF TRIP (School, Meeting, Convention, etc.): Workshop

Childhood Lead Poisoning Prevention Workshop (Name) | 11/15/99-11/18/99 (Date) | Louisville, Kentucky (Location)

MODE OF TRAVEL (Private - Public): Public - Air

contract w/disc.

ESTIMATED COST: $ 282.42 (Travel) $ 104.00 (per diem) $ 240-hotel 28.00-taxi (Other) $ 654.42 (Total)

JUSTIFICATION FOR TRIP: She has just started in the new position at PHN/Program Grant Consultant with the ATSDR Grant/391

The reason this is being submitted so late is that we just got permission for her to make the trip [illegible]

Contract $ 285.00 Discount $ 2.58

DURATION OF TRIP WILL INCLUDE 4 **DAYS AT MEETING AND** 1 **DAYS ENROUTE.**

TOTAL OF 5 **DAYS.**

APPROVED: _____
Service or Office Chief/Division Director

APPROVAL AND TRAVEL AUTHORIZATION

The individual named hereon is authorized to perform official travel as indicated.

_____ Commissioner

_____ Date

OSDH Form No. 81
(Rev. 8/78)

OSF Form 19
Revised 1/89

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		101443

FOR AGENCY USE: B700 N297 03060

CLAIM OF: Carol Abbott

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

7/13/00

FOR $ 197.28 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of H.

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	000035	42000	2111	93800 D	197.28
NO X					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____	OSF - Audited By:			TOTAL AMOUNT $	197.28

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Shawnee	Performs nursing services for the Children First program.

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Mlg	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Prs.	Per Diem Rate	Amount	Lodging Amount
Shawnee-Vicinity-Return	06	01		14							
Shawnee-Prague-Shawnee	06	01	52								
Shawnee-McLoud-Bethel Acres	06	01	27	11							
Shawnee-Vicinity-Return	06	05		15							
Shawnee-Vicinity-Return	06	06		09							
Shawnee-Vicinity-Return	06	07		09							
Shawnee-Tecumseh-Shawnee	06	07	14	22							
Shawnee-Vicinity-Return	06	08		12							
Shawnee-McLoud-Shawnee	06	08	28	08							
Shawnee-Vicinity-Return	06	12		08							
Shawnee-Vicinity-Return	06	14		04							
Shawnee-McLoud-Shawnee	06	14	28	16	(SEE ADDENDUM)						
TOTALS			327	280							
			607		TOTAL MILES @	.325			PER MILE =		$197.28

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
*Home Visit after 5:00pm-Residence closer		TOTAL AMOUNT CLAIMED $197.28

I, Carol Abbott the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Carol Abbott 7-5-00
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me _____, 19 ____.

My Commission expires _____, 19 ____. _____
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Officer

Agency Chief Financial Management

JUL 17 2000
Title Date

Agency, Bd., or Div. Use Pott. Co. Health Dept.
1904 Gordon Cooper Drive
Shawnee, OK 74801-8698

Name Abbott, Carol SSN PERSONAL IDENTIFIER(S) REDACTED

Show point travel status began, each point visited, and the point travel status ended. (Vicinity only travel should show general geographnical area, e.g., Tulsa Vicinity).	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	Total Per Diem Lodging
Shawnee-Vicinity-Return	06	15		10								
Shawnee-Prague-Shawnee	06	15	52									
Shawnee-BethelAcres-Shawnee	06	15	28									
Shawnee-Vicinity-Return	06	19		22								
Shawnee-Vicinity-Return	06	20		08								
Shawnee-BethelAcres-Shawnee	06	20	28									
Shawnee-Vicinity-Return	06	21		08								
Shawnee-Tecumseh-Shawnee	06	21	14	22								
Shawnee-Vicinity-Return	06	22		12								
Shawnee-Vicinity-Return	06	27		04								
Shawnee-BethelAcres-Shawnee	06	27	28									
Shawnee-Vicinity-Return	06	28		04								
Shawnee-McLoud-Shawnee	06	28	14	24								
Shawnee-Vicinity-Return	06	29		10								
Shawnee-Tecumseh-Shawnee	06	29	14	28								
TOTALS												
					TOTAL MILES @					PER MILE =		

ODH 19-1 (10/96)

Name Abbott, Carol SSN PERSONAL IDENTIFIER(S) REDACTED

Show point travel status began, each point visited, and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity).	Date 2000		Mileage Claimed		Travel Status Hour		No. of		Per Diem		Lodging	Total Per Diem Lodging
	Mo.	Day	Map	Vicinity	Entered	Ended	Days	Hrs.	Rate	Amount	Amount	
Shawnee-Vicinity-Return	06	15		10								
Shawnee-Prague-Shawnee	06	15	52									
Shawnee-Bethel Acres-Shawnee	06	15	28									
Shawnee-Vicinity-Return	06	19		22								
Shawnee-Vicinity-Return	06	20		08								
Shawnee-Bethel Acres-Shawnee	06	20	28									
Shawnee-Vicinity-Return	06	21		08								
Shawnee-Tecumseh-Shawnee	06	21	14	22								
Shawnee-Vicinity-Return	06	22		12								
Shawnee-Vicinity-Return	06	27		04								
Shawnee-Bethel Acres-Shawnee	06	27	28									
Shawnee-Vicinity-Return	06	28		04								
Shawnee-McLoud-Shawnee	06	28	14	24								
Shawnee-Vicinity-Return	06	29		10								
Shawnee-Tecumseh-Shawnee	06	29	14	28								
TOTALS												
					TOTAL MILES @					PER MILE =		

ODH 19-1 (10/96)

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		101327 MT

FOR AGENCY USE: BT00 NW97 01249Y

CLAIM OF: Ottawa Nancy Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 7/5/00

FOR $ 61.75 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

IS CAR GOV. OWNED? YES ___ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	92000	2111	93.200 0000	61.75

OSF - Audited By:

TOTAL AMOUNT $ 61.75

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391-Lead Project

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7054004
WARR DATE: 07/17/2000
CLAIM NO: 101327

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Picher-Miami	06	09	20	02							
Miami-Picher-Miami-Picher-Miam	06	10	20								
Miami-Picher-Mia.-Picher-Miami	06	14	40								
Miami Vicinity	06	15		06							
Miami Vicinity	06	16		16							
Miami Vicinity	06	20		06							
Miami-Picher-Miami	06	22	20	06							
Miami-Cardin-Miami	06	22	14								
Miami-Picher-Miami	06	26	20								
TOTALS			154	36	190	TOTAL MILES @ .325				PER MILE =	61.75

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP. 61.75
		TOTAL AMOUNT CLAIMED

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy Horton
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 6-30-00, 19 ___

My Commission expires _____ 19 ___

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Chief, Financial Management

Agency's Approving Officer

JUL 13 2000

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Title

Agency, Bd., or Div. Use

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		101329

FOR AGENCY USE: BT00 NW 97 01174B

CLAIM OF: OTTAWA
Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED
MK 7/5/00

FOR $ 68.25 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

IS CAR GOV. OWNED? YES ___ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	2111	93.300 0000	68.25

OSF - Audited By:

TOTAL AMOUNT $ 68.25

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR DATE: 07/17/2000
WARR NUM: 7034000
CLAIM NO: 101329

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391-Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1/2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Commerce-Miami	06	01	08	02							
Mia-Vinita-Mia.-Commerce-Miami	06	02	62	02							
Miami Vicinity	06	06		04							
Miami-Vicinity	06	08		06							
Miami Vicinity	06	13		10							
Miami-[illegible]-Commerce-Mia	06	14	28	06							
Miami Vicinity	06	15		08							
Miami Vicinity	06	20		10							
Miami Vicinity	06	21		10							
Miami Vicinity-Oicher-Miami	06	22	20	12							
Miami Vicinity	06	26		10							
Miami Vicinity	06	27		12							
TOTALS			118	92							
				210	TOTAL MILES @ .325				PER MILE =		68.25

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 68.25

I, Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 6-30-00, 19 ___

My Commission expires _____, 19 ___

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act of _____

Chief, Financial Management

Agency's Approving Officer

Title

Agency, Bd., or Div. Use

JUL 13 2000
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		037709pr

FOR AGENCY USE: BTD NW97 012494

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ___ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
01035	42000	2111	93.2000000	29.90

OSF - Audited By:

TOTAL AMOUNT $ 29.90

FOR $ 29.90 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Hea

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 0176534
WARR DATE: 06/19/2000
CLAIM NO. 037709

OFFICIAL DUTY STATION: MIAMI/~~OTTAWA~~

NATURE OF OFFICIAL BUSINESS: 391- LEAD GRANT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	5	1		6							
Miami-Picher-Miami	5	4	20								
Miami-Vicinity-Miami	5	12		12							
Miami-Picher-Miami	5	13	20								
Miami-Vicinity-Miami	5	16		12							
Miami-Vicinity-Miami	5	17		6							
Miami-Vicinity-Miami	5	23		6							
Miami-Vicinity-Miami	5	24		4							
Miami-Vicinity-Miami	5	25		6							
TOTALS			40	52	92						
			92		92	TOTAL MILES @	32.5¢		PER MILE =		$29.90

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. $29.90

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $29.90

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 5-30, 2000

My Commission expires ___, 19__

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act of

Agency's Approving Officer

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI OKLAHOMA 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		114786

FOR AGENCY USE: BT01 NW97 012494

OTTAWA

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

FOR $ 272.75 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dep

ASSIGNMENT
I hereby assign this claim to [illegible]
and authorize the State Treasurer to iss warrant in payment to said assignee.
Date:
Claimant Signature

WARR DATE: 11/21/2000
WARR NUM: 7478594
CLAIM NO: 114786

IS CAR GOV. OWNED? YES ___ NO XX ✓

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX ✓ NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00135	40000	2111	53200 0000	198.25
		2114		4.50
		2112		20.00

OSF - Audited By:

TOTAL AMOUNT $ 272.75

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
* Miami-Vic.-tulsa-Bristow	10	4	121	9	16:00						
* Bristow-Tulsa-Bristow	10	5 ✓	64				~~1~~	✓		$35.00	
* Bristow-Tulsa-Vic.-Miami	10	6 ✓	121	3		17:00	~~1~~ 2	1		$35.00	
Miami-Wyandotte-Vic.-Miami	10	9		30						10.00	
Miami-Commerce-Miami	10	11	8								
Miami-Afton-Vicinity-Miami	10	13	30	6							
Miami-Wyandotte-Vic.-Miami	10	14		30							
Miami-Picher-MIami	10	16	20								
Miami-Picher-Miami-Picher-Miami-Picher-Miami-Picher-Miami	10	17	60								
Miami-Picher-Wyandotte-Picher-Vicinity-Miami	10	18	40	30							
TOTALS			484	126							$ 70.00
			610		610 TOTAL MILES @		32.5¢		PER MILE =		$198.25 ✓

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. $268.25

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $4.50	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 4.50
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	$268.25
		TOTAL AMOUNT CLAIMED	$272.75

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 10-31 2000

My Commission expires _____, 19__

Susan A. Waldron
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

NOV 17 2000

State Travel Reimbursement Actor

Agency's Approving Officer: Chief Financial Management

Title

Agency, Bd., or Div. Use: OTTAWA COUNTY HEALTH DEPT. 1930 NORTH ELM MIAMI, OKLAHOMA 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
	340		

FOR AGENCY USE

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO XX

AGENCY NO.
PERSONAL IDENTIFIER(S)

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES XX
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
OSF - Audited By:			TOTAL AMOUNT $	

FOR
$
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

_____
Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	TOTAL PER DIEM LODGING
Miami-Quapaw-Miami	10	23	20									
Miami-Vicinity-Miami	10	26		6								
Miami-Vicinity-Miami	10	27		6								
Miami-Vicinity-Miami	10	30		6								
Advance portion in lieu of subsistence												

Friday, October 6, 2000

sessions

2:30 - 2:45 Break

2:45 - 3:45 Small Sessions

A. Recognizing Attachment Disorders and What to Do About Them – (Age Appropriate)
Mark Jones, MEd, LPC

*B. Shaken Baby Syndrome (Part 2)
Karen Cornell, EdD, LPC
Donna Jones, MEd, CCPS

C. Obesity in Children and Relationship to Adult Obesity
Cathy Montgomery, MS, RD/LD

D. Hepatitis B and C
Sheldon Berger, DO

*E. Tailoring Health Messages for the Adolescent Audience
James Allen, MPH, CHES

3:45 Adjourn Turn in Evaluations at the Registration Desk

*C-1 CE Approved

11.8 contact hours approved by the Colorado Nurses' Association.
CNA is accredited as an approver of CE for nursing by The American Nurses Credentialing Center's Commission on Accreditation.

planning committe

Jan [illegible] MT (ASCP) CLS(NCA)
OSDH - Public Health Laboratory Service

[illegible] D, ARNP
Carter County Health Department

Lashawn Bollenbach, AD, RN
Washington County Health Department

Susan Boyd, MS, RN
OSDH - Nursing Service

Jana Boydstun, LPN
Comanche County Health Department

Kristy Bradley, DVM, MPH
OSDH - Acute Disease Service

Ken Cadaret, MPH, RNC
OSDH-Maternal and Child Health Service

Connie Childress
Pontotoc County Health Department

Linda Council, MPH, ARNP
OSDH - HIV/STD Service

David Davis, BSN, RN
Oklahoma County Health Department

Toni Frioux, MS, CNS, ARNP
OSDH - Nursing Service

[illegible]n, BSN, RN
Tulsa City-County Health Department

John Hitz, DrPH, HCLD
OSDH - Public Health Laboratory

Misty Jackson
Custer County Health [illegible]

Tina Johnson, AD, RN
OSDH - Nursing Service

Marolyn [illegible], LPN
Carter County Health Department

Darla [illegible]
Beckham County Health Department

Nancy Nelson, MS, CHES, RN
Tulsa City - County Health Depart[illegible]

Kathy Payne, MHR, AASECT
OSDH - Maternal and Child Health Service

Judy Pekrul, RN
Garfield County Health Department

Cindy Rogers, BSN, ARNP
Sequoyah County Health Department

Janet Roseman, RN, RD/LD
OSDH - WIC Service

Katie Sampson
Pontotoc County Health Department

Mendy Scherman, MPH
OSDH - Injury Prevention Service

Pat Scott, BS, ARNP
OSDH - Maternal and Child Health Service

Roberta Se[illegible]SN
Kingfisher County Health Depart[illegible]

Terri Tate, BSN, RN
Seminole County Health Depart[illegible]

Nancy Watson, AD
Stephens County Health Depart[illegible]

Special Note: Children First Continuing Education approval has been given for those sessions designated with an astrisk.

purpose

Public health is proud of its traditions and prepared to face the future as advocates for health. This practice necessitates constant assessment, policy development, and assurance activities of staff working in partnerships and collaborating with others. The future public health role is the same as the past role: use nursing and public health skills to assess the needs and strengths of the population, design interventions, and mobilize resources for action to assure healthy populations.

objectives

- Educate the importance of healthy families in communities.
- Examine how public health strategies can improve healthy relationships.
- Examine different program issues as they relate to improving healthy relationships.
- Illustrate innovative health promoting ideas implemented in the health department and community setting using a poster presentation.

	Registration
7:30 -	Breakfast
9:00 - 9:30	Welcome and Introductions
9:30 - 10:30	Solving the Relationship Equation: You + Me = Us Keynote
10:30 - 11:00	Break
11:00 - 12:00	Small Sessions

A. Making Monogamous Relationships Appealing
TBA

B. Breast Exam Uncovers a Lump – What Now
Charlotte Coffey, MSW
Susan Lamb, BA

C. How to Stop the Lines in August
Don Blose - Panel

*D. Incentives to Keep Families Engaged in Health Department Programs
Barbara McEndree, MS, ARNP, CNS

E. Eating Disorders – How to Spot and How to Intervene
Kathy Onley, PhD

F. Karen Konnects with Kids about Kontraception – So Kan You
Karen Waldron, RN, ARNP

12:00 - 1:00 Lunch - On Your Own

*C-1 CEA

Small Sessions

A. Having a Baby Does Not Make a Teen an Adult
Built Does Make a Family
Dian England, MSW

Disaster and Relationship of Community Resources
Kim Young

C. Can Behaviors Change - Hypertension, Obesity, Diabetes and Heart Disease
Montes Mutzig, MD

D. The Pros and Cons of a Driveby Flu Clinic
Panel:
Payne: Belinda Hammergren, RN
Craig: Kay Wright, RN
Muskogee: Jamie Mathews, RN
Wagoner: Julia Phillips, RN

E. Class Womb Project
Diane McCright, MSN, BSN, ARNP

*F. What Happens after a Referral Is Made to DHS
Vanessa Wedlake, BS

2:30 - 3:30 Small Sessions

A. Communicable Disease in the News
Michael Crutcher, MD

*B. Dealing with Anger: Difficult Client
Ray McCaffrey, PhD

*C. OTC Medications to Avoid While Pregnant
Jon Calvert, MD

D. Counseling Techniques for Partners of STD Clients with Condylomas
James Radike, MD

E. Get the Lead Out! (Paint, Slides, Pottery)
Kim Cadaret, MPH, RNC
Kirby Moss, BS
Susan Waldron, BA
Nancy Horton, BSN, RN

*C-1 CE Approved

Break

Small Sessions

A. Coordinating/Lead Nurse Session -
How to Prepare in Court
Phil Frazier, JD

(No CE's) B. LPN/PCA Session -
Interpreting Growth Grids
Debbie Farley, BSN, ARNP

*C. Keeping Males in the Picture
Cecil Hancock

*D. Motivating Those Who Appear Hopeless
Bruce Lutz, EdD, LMFT, LPC

*E. Nuturing Work Force Relationships –
Dealing with Impossible People
Ivey Ragsdale, MHR

*C-1 CE Approved

8:30 - 9:

B. Identification of Depression or Suicidal Ideation in Adolescents
Steve Nedbalak, BSEd, MS

C. Get the Story Straight
Marilyn Lanphier, MPH, RN, FSAM
Kathy Payne, MHR, AASECT

*D. Mediation in Custody and Child Support Disputes
Hugh Rineer, JD
Mary Rineer, PhD

*E. Common Warning Signs of Neglect
Cheryl Thornton, MSW

F. Have Breast Will Travel - Breastfeeding
Crystal Stearns, RNC, MS, IBCLC

9:30 - 9:45 Break

9:45 - 10:

A. Building Self Esteem
Ann Benjamin, MEd, LPC

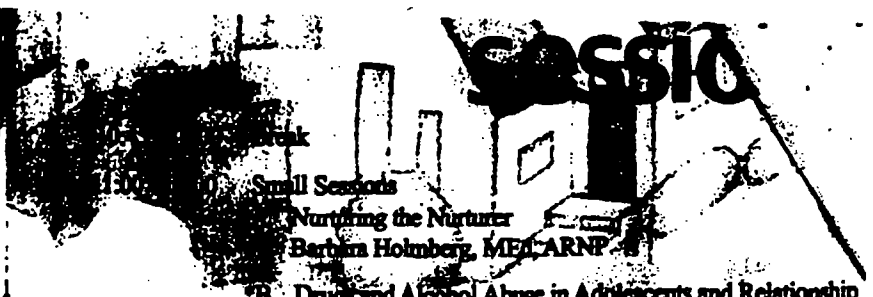
B. Fathering and Bonding
Mark Jones, MS, MBA, LPC, LM

C. Unequal Power – Addressing Power and Control Relationships
Robert Boland, EdD, LMFT
Terning, MEd, ICADA

Foods Appealing to Children 1-5 Years of Age
Gabriel, RD/LD

E. Recognizing Serious Drug Interaction
TBA

*C-1 CE Approved



Break

1:00 - Small Sessions

Nurturing the Nurturer
Barbara Holmberg, MED, ARNP

*B. Drugs and Alcohol Abuse in Adolescents and Relationship to Risk Taking Behaviors
Mike Boss, LCDC, CADC

*C. Learned Helplessness vs Optimism in Children
Mary Rineer, PhD

*D. How to Discipline Children Under 5
Carol McCoy, MEd, LPC

*E. Promoting Excellent Nutrition in Children Through Proper Nutrition
Cindy Arnold, MS, RD/LD

F. Dermatology Conditions Related to STDs - Video
David Davis, RN

12:00 - 1:30 Lunch - On Your Own

1:30 - 2:30 Small Sessions

A. Discipline and Today's Adolescent
Robert Block, MD, FAAP

B. Interpreting Pap Smear Results
Rosemary Zuna, MD

C. Baby Wise Alert! The Ezzo Parenting Method
Ellen Johnsen, RN, BA

D. Syphilis and New Issues
Mark Turner

Shaken Baby Syndrome (Part 1)
Cornell, EdD, LPC
Johns, MEd, CCPS

*F. Teaching Injury Prevention for the Whole Family
Mandy Scherman, MPH

*C-1 CE Approved

Oklahoma State Department of Health
Creating a State of Health
Jerry Regier, Acting Director and
Secretary of Health and Human Services

MEMORANDUM

August 25, 2000

TO: Public Health Nursing Conference Participant

THROUGH: Toni Frioux, MS, CNS, ARNP
Chief, Nursing Service

FROM: Tina Johnson, RN
Director, Nursing Education

SUBJECT: 16th Annual Public Health Nursing Conference

Nursing Service is pleased to announce the 16th Annual Public Health Nursing Conference. The conference will be held October 5 - 6, 2000, at the Doubletree Hotel Downtown in Tulsa. There will be complimentary parking for all participants during the conference. We anticipate this conference to be both an enjoyable and productive experience.

Enclosed with this letter you will find:

- Public Health Nursing Conference Brochure
  NOTE: Make a note of your selections and bring your copy of the brochure to the conference as a reference.
- Pre-Conference Flyer - Relationships
- Speakers' objectives to assist you in your session choices.
- Memorandum regarding Conference/Meeting Etiquette
- A map of the area to locate the hotel.
- Doubletree Hotel Downtown Tulsa Sleeping Room Reservation Form

For those counties who wish to participate, door prize donations will be collected at the registration desk. Nursing Service and the Conference Planning committee wish to acknowledge those being honored. A certificate and special corsage can be picked up at a table by the registration desk. The exhibitors will be having their displays on Thursday only. The poster presentations will be on display Friday from 8:00 a.m. to 1:00 p.m. in the exhibit area. We look forward to seeing you in October.

Enclosures

Board of Health
Jay A. Gregory, MD, President
John B. Carmichael, DDS
Dan H. Fieker, DO
Ron L. Graves, DDS, Vice President
Gordon H. Deckert, MD
Ron Osterhout
Haskell L. Evans, Jr, RPh, Secretary-Treasurer
Glen E. Diacon, Jr, MD
R. Brent Smith, MD

1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us

Oklahoma State Department of Health
Creating a State of Health
Jerry Regier, Acting Director and
Secretary of Health and Human Services

RECEIVED
SEP 25 2000
OTTAWA COUNTY HEALTH DEPT.

Kim

MEMORANDUM

September 18, 2000

TO: Public Health Nursing Conference Participant

THROUGH: Stephen W. Ronck, M.P.H., Acting Deputy Commissioner
Local Health Services

FROM: Toni D. Frioux, M.S., C.N.S., A.R.N.P.
Chief, Nursing Service

SUBJECT: Designated Hotel for Sixteenth Annual Public Health Nursing Conference

The Oklahoma State Department of Health is the sponsor for the objective of travel to the 16th Annual Public Health Nursing Conference on October 5-6, 2000 and the Relationship Pre-conference on October 4, 2000. The conference and pre-conference will be held at the DoubleTree Hotel Downtown, 616 West 7th Street, Tulsa, Oklahoma. There is no registration fee.

A block of rooms has been reserved for the nights of October 3-5, 2000 for the following rate plus tax:

Singles	$60.00
Doubles	$60.00
Triples	$60.00
Quads	$60.00

Due to the overwhelming response, the following alternate hotel has been reserved for overflow for the same rate as above plus tax:

Ramada Inn Downtown Plaza
17 West Seventh Street
Tulsa, OK, 918-585-5898

Please submit this letter and a copy of the PHN Conference brochure with your travel claim for full reimbursement.

cc: Administrators, Headquarter Counties

TF:jd

Board of Health
Jay A. Gregory, MD, President
John B. Carmichael, DDS
Dan H. Fieker, DO
Ron L. Graves, DDS, Vice President
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Ron Osterhout
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R. Brent Smith, MD

1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us

Oklahoma State Department of Health
Creating a State of Health
Jerry Regier, Acting Director and
Secretary of Health and Human Services

RECEIVED
SEP 28 2000
OTTAWA COUNTY HEALTH DEPT.

TO with
go travel
thanks Nancy

September 26, 2000

Nancy Horton, BSN, RN
1930 North Elm
Miami, OK 74354

Dear Nancy,

Enclosed is the information regarding your presentation on, Thursday, October 5 at 2:30 - 3:30, Session E entitled Get the Lead Out! (Paint, Slides, Pottery).

Number attending as of this date:	50
Room:	Windsor
Moderator:	Neoma Vanzant
Video Equipment Requested	Lecture, Demonstration, Handout, PowerPoint

The number attending your session is correct as of September 26, but is subject to change due to late registrations.

You will be provided a microphone and podium. A 6-foot screen will be available in rooms with presentations requiring AV equipment. Also enclosed is a sample evaluation form that will be used to evaluate your presentation. For your convenience we have included a map of the meeting rooms and a brochure.

We look forward to hearing your presentation. Please do not hesitate to call if I can be of further assistance at (405) 271-5183.

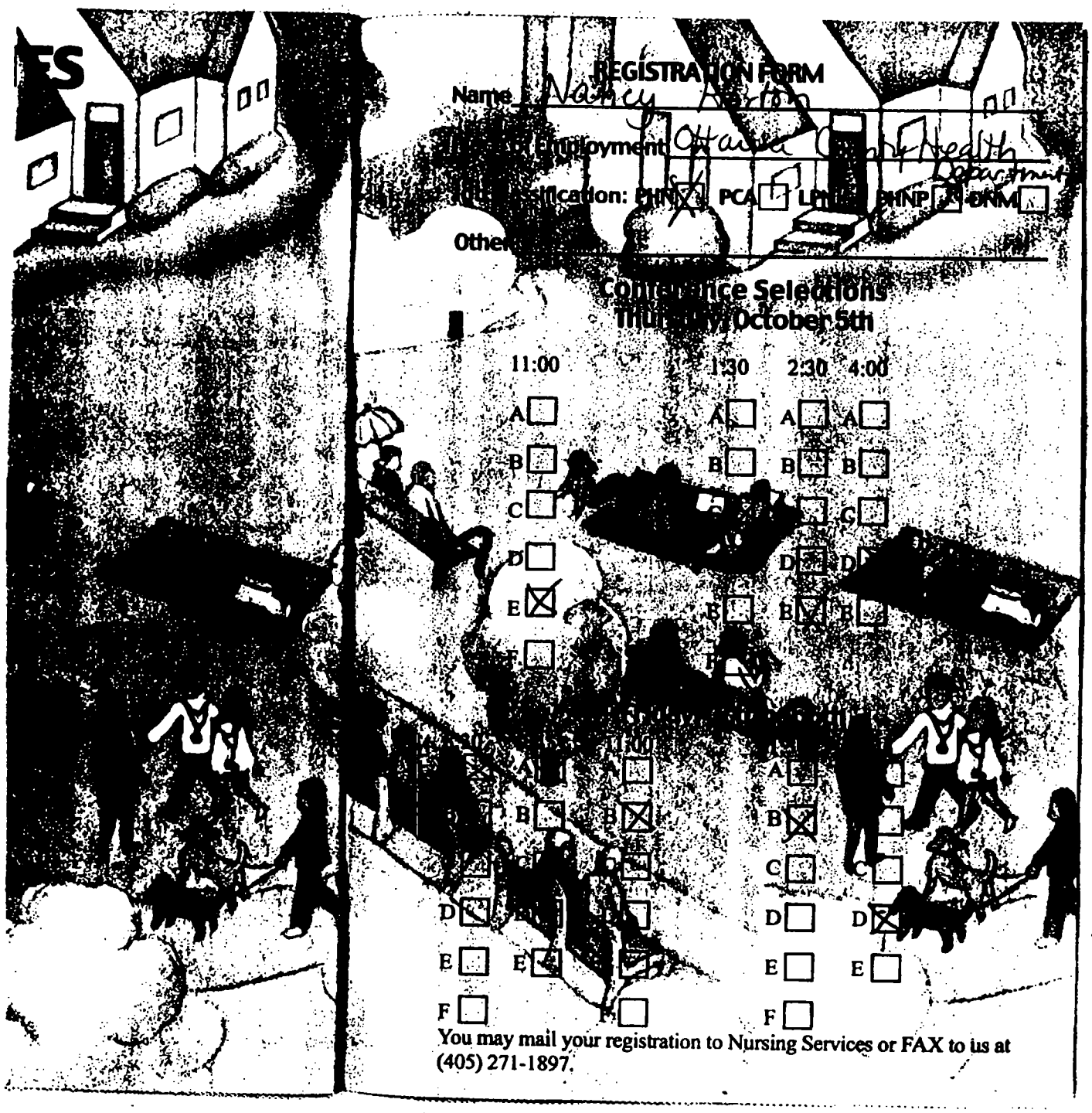
Sincerely,

Tina Johnson, R.N.
Director of Nursing Education
Nursing Service

Attachments

Board of Health
Jay A. Gregory, MD, President
John B. Carmichael, DDS
Dan H. Fieker, DO
Ron L. Graves, DDS, Vice President
Gordon H. Deckert, MD
Ron Osterhout
Haskell L. Evans, Jr, RPh, Secretary-Treasurer
Glen E. Diacon, Jr, MD
R. Brent Smith, MD

1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us



REGISTRATION FORM

Name Nancy Aaron

Employment Oklahoma City-County Health Department

Classification: PHN ☒ PCA ☐ LPN ☐ PHNP ☐ ONM ☐

Other

Conference Selections
Thursday, October 5th

	11:00	1:30	2:30	4:00
A	☐	☐	☐	☐
B	☐	☐	☐	☐
C	☐		☐	☐
D	☐		☐	☐
E	☒		☐	☐
F	☐			

Friday, October 6th

	11:00		
A	☐	☐	☐
B	☐	☒	☒
C	☐	☐	☐
D	☒	☐	☐
E	☐	☒	☐
F	☐	☐	☐

You may mail your registration to Nursing Services or FAX to us at (405) 271-1897.

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		110554

FOR AGENCY USE: BT01 NW97 012494

Ottawa

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ___ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2111	93.200	77.68

OSF - Audited By:

TOTAL AMOUNT $77.68

FOR $ 77.68 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of H

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7554062
WARR DATE: 10\10\2000
CLAIM NO: 110554

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391-Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Picher-Vicinity-Miami	9	6	20	25							
Miami-Picher-Vicinity-Miami	9	7	20	5							
Miami-Vicinity-Miami	9	8		8							
Miami-Quapaw-Vicinity-Miami	9	15	20	2							
Miami-Vicinity-Miami	9	19		6							
Miami-Picher-Vicinity-Miami	9	19	20	8							
Miami-Picher-Vicinity-Miami	9	22	20	54							
Miami-Vicinity-Miami	9	29		6							
Miami-Picher-Vicinity-Miami	9	29	20	5							
TOTALS			120	119							
			239		239	TOTAL MILES @	32.5¢		PER MILE =		$77.68

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. $77.68

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):
SHUTTLE:	TELEPHONE: TOLLS:
RENTAL CAR:	PARKING: TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC COSTS: TOTAL LOCAL TRANSP.
	TOTAL AMOUNT CLAIMED $77.68 ✓

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 10-02 2000

My Commission expires ___, 19__

Susan Waldron
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Chief, Financial Management
Agency's Approving Officer

OCT 12 2000
Date

Title OTTAWWA COUNTY HEALTH DEPT.
Agency, Bd. or Div. Use 1930 North Elm
MIAMI, OK 74354

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		107835

FOR AGENCY USE: BTOI NW97 02494

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MIC 9/7/00

FOR $ 99.45 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of He

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	00135	40000	2111	93200000	99.45
NO XX					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	99.45

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead Program

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	8	1		8							
Miami-Commerce-Miami	8	1	8								
Miami-Vicinity-Miami	8	3		16							
Miami-Vicinity-Miami	8	7		6							
Miami-Quapaw-Miami	8	8	20								
Miami-Vicinity-Miami	8	9		12							
Miami-Vicinity-Miami	8	10		8							
Miami-Vicinity-Miami	8	11		8							
Miami-Vicinity-Miami	8	12		10							
Miami-Commerce-Vicinity-Miami	8	14	8	8							
Miami-Wyandotte-Vicinity-Miami	8	15		30							
Miami-Picher-Vicinity-Miami	8	15	20	50							
TOTALS			78	228							
			306		306	TOTAL MILES @	32.5¢		PER MILE =		$99.45

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:		TELEPHONE:	TOLLS:	
RENTAL CAR:		PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	$99.45

I, Nancy Horton the undersigned, upon oath do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and outstanding as stated, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 08-31 , 2000

My Commission expires _____ , 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

RECEIVED
2000 SEP -8 A 10:11

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Authorized Official

Title

Agency, Bd., or Div. Use

SEP 14 2000
County Health Dept.
930 North Elm
Miami, Oklahoma 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
	340		

FOR AGENCY USE

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____					
NO XX					
LICENSE NO.					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	

FOR
$
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

_____
Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391- Lead Pregram

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Date Day	Mileage Claimed Map	Mileage Claimed Vicinity	Travel Status Hour Entered	Travel Status Hour Ended	No. of Days	No. of Hrs.	Per Diem Rate	Per Diem Amount	Lodging Amount	TOTAL PER DIEM LODGING
Miami-Fairland-Vicinity-Miami	8	22	22									
Miami-Vicinity-Miami	8	23		12								
Miami-Vicinity-Miami	8	24		12								
Miami-Vicinity-Miami	8	25		12								
Miami-Vicinity-Miami	8	30		6								
Miami-Wyandotte-Vicinity-Miami	8	31		30								
TOTALS												

Ottawa Hn

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO. 8
400	340		107834

FOR AGENCY USE: BT01 NW97 OH49Y

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 9/7/00

FOR $ 36.40 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

IS CAR GOV. OWNED? YES ___ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	40000	2111	13200000	36.40

OSF - Audited By:

TOTAL AMOUNT $ 36.40

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date:

Claimant Signature

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead Program

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	7	18		8							
Miami-Vicinity-Miami	7	19		10							
Miami-Vicinity-Miami	7	21		8							
Miami-Vicinity-Miami	7	24		16							
Miami-Vicinity-Miami	7	26		30							
Miami-Commerce-Miami	7	26	8								
Miami-Vicinity-Miami	7	27		14							
Miami-Vicinity-Miami	7	28		8							
Miami-Vicinity-Miami	7	29		10							
TOTALS			8	104							
			112		112 TOTAL MILES @		32.5¢		PER MILE =		$36.40

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE:	TOLLS:
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $36.40

I, NANCY HORTON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 08-31 2000

My Commission expires _____, 19__

Susan Waldron
Approving Supervisor's Signature

Notary Public (or Clerk or Judge)

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Chief, Financial Management

Agency's Approved Officer

SEP 14 2000

Title Date

Agency, Bd., or Div Use

Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354

Ottawa [illegible]

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		110547 pr

FOR AGENCY USE: BTC1 NW99 01148

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X

PERSONAL LICENSE NO. [illegible] REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2111	9320000	195.98
		2112		~~[illegible]~~ 75.00
		2114		12.50
		2115		133.92

OSF - Audited By:

TOTAL AMOUNT $ 417.40

FOR $ 417.40 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Hea

WARR NUM: 7354675
WARR DATE: 10/16/2000
CLAIM NO: 110547

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: 391- LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	Lodging
MIAMI-NORMAN	09	12	208		1:30PM						44.64	44.64
NORMAN VICINITY	09	13		10							44.64	44.64
NORMAN VICINITY	09	14		10							44.64	44.64
NORMAN VICINITY-OKC-MIAMI	09	15	211	10		4:34 pm	3	3	25	75.00		75.00
MIAMI-VINITA-MIAMI VICINITY	09	18	54	06								
MIAMI VICINITY	09	19		08								
MIAMI-COMMERCE-MIAMI	09	21	08	02								
MIAMI VICINITY	09	25		16								
MIAMI-VINITA-MIAMI	09	29	54	06								
TOTALS			535	68								208.92
				603	TOTAL MILES @				.325		PER MILE =	195.98

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS:	12.50
RENTAL CAR:	PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	417.40

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 10-2-2000 19 ____

My Commission expires _____, 19 ____

Notary Public (or Clerk or Judge)

Jane Ann Nichols
Approving Supervisor's Signature

RECEIVED
2000 OCT -2 [illegible]

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Chief, Financial Management

Agency's Approving Officer

OCT 12 2000

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354.

Title

Agency, Bd., or Div.

NORMAN FAIRFIELD INN
301 NORMAN CENTER CT
NORMAN, OK 73072
405-447-1661

Arrival: 9/12/00
Departure: 9/15/00

Guest Name: WALDRON, SUSAN
Address: 1000 NE 10TH STREET ROOM 119
Oklahoma City, OK 73117
USA

Mbr. ID:
Level:

Room: 109
Folio Id: 14370 - 2ZX
Plan: GOVV

Date	Description	Reference	Charges	Credits	Balance
9/12/00	Regular Room Charge	Room 109	$40.00	$0.00	$40.00
9/12/00	Occupancy Tax	Room 109	$1.60	$0.00	$41.60
9/12/00	State Tax	Room 109	$3.04	$0.00	$44.64
9/13/00	Regular Room Charge	Room 109	$40.00	$0.00	$84.64
9/13/00	Occupancy Tax	Room 109	$1.60	$0.00	$86.24
9/13/00	State Tax	Room 109	$3.04	$0.00	$89.28
9/14/00	Regular Room Charge	Room 109	$40.00	$0.00	$129.28
9/14/00	Occupancy Tax	Room 109	$1.60	$0.00	$130.88
9/14/00	State Tax	Room 109	$3.04	$0.00	$133.92
9/15/00	Visa	THANK YOU	$0.00	-$133.92	$0.00

NORMAN FAIRFIELD #167
301 NORMAN CENTER COURT
NORMAN, OK. 73072
405-447-1661

MERCHANT ID: 1381512886095
DATE: 09/15/00 3:14:00 PM

* CHECK OUT *

RECORD NUMBER: 00011
ROOM #: 167
ACCOUNT: PERSONAL IDENTIFIERS(S) REQUIRED
CARD TYPE:
TRAN TYPE: CHECK OUT
CHECK IN DATE: 09/12/00
CHECK OUT DATE: 09/15/00
AUTH CODE: 267165

TRAN TYPE	AUTH CODE	TRAN AMOUNT	TRAN DATE
CKIN	267165	150.00	091500

TOTAL APPROVED: 1 ITEMS 150.00

FINAL AMOUNT: 133.92

I AGREE TO PAY THE ABOVE AMOUNT
ACCORDING TO CARD ISSUER AGREEMENT.
PLEASE IMPRINT CARD

TOP COPY MERCHANT
BOTTOM COPY TO CUSTOMER

$0.00

X _____

Cardholder acknowledges receipt of goods and/or services in the amount of the total shown above and agrees to perform the obligations and terms in the cardholder agreement with the seller.

September 13, 2000

Memorandum

From: Diane Biard–Holmes, Chief,
Human Resources Management Division

Subject: OPHLI Conference

The 2000 Oklahoma Public Health Leadership Institute has been scheduled as follows:

Date and time: September 13 2000 (8:00 AM to 4:30PM)
September 14,2000 (8:00 AM to 4:30PM)
September 15,2000 (8:00 AM to 4:30PM)

Place: OU/DHS Training Center, Norman, OK

Designated Motel: Norman Fairfield Inn
301 Norman Center Court
Norman, OK 73072
Phone/Fax: (405) 447-1661

Room Rate: $40.00 plus $4.64 tax = $44.64

OKLAHOMA PUBLIC HEALTH LEADERSHIP INSTITUTE

September 13, 14, & 15, 2000
OU/DHS TRAINING CENTER
Norman, Oklahoma

MODULE 2

Building Leadership Skills to Strategically Plan for Betterment of Community Health

Wednesday, September 13, 2000

8:30	**Leadership — Giants See Opportunity Where Others See Trouble** **Presenter**: *Lori Smith, M. S.* One of the greatest challenges facing any organization today is to develop the adaptive capacity required to effectively respond to a constantly changing environment. In this light, it is useful to think of leadership not as a position of authority, but as an activity designed to build the adaptive capacity within the group. Long term success for any organization is dependent upon nurturing and developing talented individuals. Ms. Smith's presentation will explore this fascinating group dynamic and share appropriate strategies for increasing your chances of success at leading in a changing environment.
12:00	**Lunch**
1:00-4:00	**Leadership — Giants See Opportunity Where Others See Trouble** (continued)
4:00-4:30	**Wrap-up, Evaluation, Adjourn**

OKLAHOMA PUBLIC HEALTH LEADERSHIP INSTITUTE

September 13, 14, & 15, 2000
OU/DHS TRAINING CENTER
Norman, Oklahoma

MODULE 2

Building Leadership Skills to Strategically Plan for Betterment of Community Health

Thursday, September 14, 2000

8:30	**Working Through Conflict** **Presenter:** *Linda Dowling, Communication Concepts, Inc.* This session will explore the process of communicating through conflict resolution. A 20-minute video will demonstrate a supervisor's perspective as facilitator in a conflict situation. Learning points will include establishing ground rules, process of communicating, and following the ground rules. The session will also focus on the practical application of communicating through conflict resolution. Participants will role-play community conflict situations in which they find themselves.
12:00	**Lunch**
1:00-4:00	**Working Through Conflict** (continued)
4:00-4:30	**Wrap-up, Evaluation, Adjourn**

OKLAHOMA PUBLIC HEALTH LEADERSHIP INSTITUTE

September 13, 14, & 15, 2000
OU/DHS TRAINING CENTER
Norman, Oklahoma

MODULE 2

Building Leadership Skills to Strategically Plan for Betterment of Community Health

Friday, September 15, 2000

8:30	**Developing Organizational and Strategic Management Skills that Lead to Improved Community Health** **Presenter:** *Keith Curtis, PH.D.,* *Associate Professor,* *Department of Health Administration and Policy* Dr. Curtis will lead the OPHLI participants in a process that will identify the issues facing their communities in the next three years. The analysis from this process will be tied to the core public health functions.
12:00	**Lunch**
1:00	**Teams Work on Projects**

 Ottawa Pol.

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		107836

FOR AGENCY USE: BT01 NW97 01174B

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ___ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2111	932000000	150.48
		2114		3.20

OSF - Audited By:

TOTAL AMOUNT $ 153.68

FOR $ 153.68 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	8	1		8							
Miami-Vicinity-Miami	8	3		8							
Miami-Claremore-Vicinity-Miami	8	4	124	10							
Miami-Vicinity-Miami	8	7		12							
Miami-Quapaw-Vicinity-Miami	8	8	20	4							
Miami-Vicinity-Miami	8	9		8							
Miami-Vicinity-Miami	8	10		8							
Miami-Picher-Vicinity-Miami	8	11	20	12							
Miami-Vicinity-Miami	8	12		6							
Miami-Commerce-Miami-Vic.-Commerce-Miami	8	14	16	4							
Miami-Wyandotte-Vicinity-Miami	8	15		35							
TOTALS			272	191							
			463		463 TOTAL MILES @		32.5¢		PER MILE -		$150.48

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. $150.48

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $3.20	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 3.20
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	~~$150.48~~
		TOTAL AMOUNT CLAIMED	$153.68

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 08-31 2000

My Commission expires _____, 19__

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act

Agency's Approving Officer

Chief Financial Management

RECEIVED SEP 14 2000

Title Ottawa County Health Dept.

Agency, Bd., or Div. Use 1930 North Elm
Miami, Oklahoma 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
	340		

FOR AGENCY USE

CLAIM OF: SUSAN WALDRON

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES XX
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
OSF - Audited By:			TOTAL AMOUNT $	

FOR
$
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

_____
Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Date 2000 Day	Mileage Claimed Map	Mileage Claimed Vicinity	Travel Status Hour Entered	Travel Status Hour Ended	No. of Days	No. of Hrs.	Per Diem Rate	Per Diem Amount	Lodging Amount	TOTAL PER DIEM LODGING
Miami-Quapaw-Vicinity-Miami	8	16	20	4								
Miami-Afton-Vicinity-Miami	8	16	30	4								
Miami-Fairland-Miami	8	22	22									
Miami-Vicinity-Miami	8	23		6								
Miami-Vicinity-Miami	8	24		10								
Miami-Wyandotte-Vicinity-Miami	8	25		40								
Miami-Vicinity-Miami	8	30		8								
Miami-Quapaw-Vicinity-Miami	8	31	20	4								

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		104970 pk

FOR AGENCY USE: BT01 NW97 01174B

Ottawa pk

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 8/10/00

FOR $ 46.15 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Heal

IS CAR GOV. OWNED? YES ____ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	40000	2111	93200-0	46.15

OSF - Audited By:

TOTAL AMOUNT $ 46.15

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: 391 - LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI-COMMERCE-MIAMI	07	06	08	02							
MIAMI VICINITY	07	07		06							
MIAMI-COMMERCE-MIAMI	07	11	08	02							
MIAMI-PICHER-MIAMI	07	13	20	04							
MIAMI-PICHER-MIAMI VICINITY	07	19	20	28							
MIAMI VICINITY	07	21		06							
MIAMI VICINITY	07	24		10							
MIAMI-COMMERCE-MIAMI	07	26	08	02							
MIAMI-VICINITY	07	27		08							
MIAMI-COMMERCE-MIAMI	07	31	08	02							
TOTALS			72	70							
				142	TOTAL MILES @		.325		PER MILE =		46.15

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 46.15

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 7-31-2000 19 ____

My Commission expires _____, 19 ____

Notary Public (or Clerk or Judge)

Jane Ann Mikol
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or [illegible] 10:3P

Chief, Financial Management

Agency's Approving Officer

AUG 16 2000

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Title

Agency, Bd., or Dept.

EQUIPMENT

9/29/1999 to 9/28/2000

Claims	16,170.32
PROGCOST - Equipment	-
Total Equipment	$ 16,170.32

Claims are the direct costs and PROGCOST are the allocated costs. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	036994

FOR AGENCY USE WARRANT # 8150842 DATE: 06/12/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	4111	000000000	9,425.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

0 3 6 9 9 4

FOR
$ 9,425.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	9,425.00
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000511

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/11/2000	383149	9,425.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 4111AAAAAX 9425.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

06/07/2000

Title Date

Agency, Bd or Div. Use

PYSOLUTIONS

P.O. BOX 12906
OKLAHOMA CITY, OKLA. 73157-2906
(405) 943-9801

RECEIVED
2000 MAY 15 P 4:29
FINANCIAL MANAGEMENT

INVOICE

★ Please pay on invoice, no statement will be sent.

INVOICE #	TERMS
383149	NET 10

SHIP VIA: OTHER

036994 PR

OKLAHOMA STATE DEPARTMENT
OF HEALTH ATTN: A/P
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
4470 T072445	KEITH HARRALSON	70496	5/11/00	5/11/00

IP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
1		EA	AFICIO COLOR 3006 SERIAL NO. 0100100116	AF3006	9425.00		9425.00	9425.0
1		EA	2-TRAY PAPER BANK SERIAL NO. 0691000235	PS380			N/C	N/
1		EA	PLATEN COVER SERIAL NO. 20750898	405149			N/C	N/
1		EA	CONTROLLER INTERFACE TYPE E SERIAL NO. 0990900145	405119			N/C	N/
1		EA	E-300 CONTROLLER SERIAL NO. 9030830130	405202			N/C	N/
			7206745 78 400BT00 000035NW97 42000	AAAAX 411H00HX PR		SUBTOTAL		9425.0
						FREIGHT		.0
						SALES TAX		.0

1.5% (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
OT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
JBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

9425.00

IKON Office Solutions

P.O. 7012445

ACCEPTANCE COPY FOR LEASE NO. 7

DATE _____ REP NUMBER F9S081 SALE TYPE SP

BILL TO _____ SIC _____ SHIP TO E92313

NAME _____ NAME Ottawa County Health Dept

DEPARTMENT RECEIVED DEPARTMENT 1930 N. Elm St.

STREET MAY 26 2000 STREET Grove, OK 74344

CITY STATE ZIP Personal Health Finance CITY STATE ZIP

BILLING

Order To Be Filled ☐ Shipping From Location _____ Order Date _____ Distribution Code _____

Order Delivered ☐ AR Code _____ P.O. Number _____ Tax Exempt Code _____

Replacement Delivery	Product Number	Equipment/Option/Accessory Detail (Include Model/Serial/MID Number)
Permanent ☐ Set-Up Fee: $ _____		Ricoh Aficio Color 3006 (RC306) Meter Reading 1,564
Loaner ☐		Install Date
	CRS203	C3006 H0100100016
Trial ☐ Shipped Via: 5-18	CRSA02	PS378 H0910600735 2RLCT
	CRSRDF	Fit. 1 K92636

FOR BRANCH INVOICING ONLY SUPPLIES ☐ Coupon - Number of Coupons Required _____

Quantity	Unit of Measure	Product No.	Description	Unit Price	Total

Comments: Delivery & Acceptance

Tax

Freight Charge

Total

CREDIT

Supplies Returned ☐ Credit To Location _____ Order Date _____ Distribution Code _____

Other ☐ AR Code _____ P.O. Number _____ Tax Exempt Code _____

Quantity	Unit of Measure	Product No.	Description	Unit Price	Total

Comments: _____

Restocking Fee

Tax

Freight Charge

Total

Jason Mitchell
Customer Technical Engineer

IKON Office Solutions, Inc.

531 East 15th Street
Joplin, MO 64804
Telephone 800 444 7214
Fax 417 781 1528

R.K. BLACK

Customer Signature (X) _____ Whse. Acknowledgement/Date _____

Date _____ Title _____ Preferred Delivery Date: _____ Business Hours: _____

Shipped _____ # of Cartons _____ Weight _____

WHITE-INVOICING OFFICE

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T075677	038168

FOR AGENCY USE
WARRANT # 8181878 DATE: 06/20/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	88042	4112	000000000	2,807.00

CLAIM OF:
DELL
742616805

0 3 8 1 6 8

FOR
$ 2,807.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	2,807.00
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000607

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
06/06/2000	383798832	2,807.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW0A 411210668X 2807.00

J/E XREF:

VENDOR: DELL MARKETING L.P.
ADDRESS: DEPT 0767
ADDRESS: P.O. BOX 120001
CITY/ST/ZIP: DALLAS TX 753120747

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

06/15/2000
Date

Agency, Bd or Div. Use

038168 Ae

DELL

This is your **INVOICE**

COPY

FID Number: 74-2616805
Sales Rep: JORDAN HAGUE
For Sales: (800)274-7799
Sales Fax: (800)433-9527
Customer Service: (800)981-3355
Technical Support: (800)981-3355
Dell Online: http://www.dell.com

Customer Number: 003844418
Purchase Order: T075677
Order Date: 06/04/00

84 01 O 01 03 N

Invoice Number: 383798832

Invoice Date: 06/06/00
Payment Terms: NET DUE 30 DAYS
Shipped Via:
Waybill Number: 078785106554107

SOLD TO:

2204-10.58-69869F13.XRX 39 of 48

ACCTS PAYABLE
OK DEPT OF HEALTH
FINANCIAL MANAGEMENT
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

SHIP TO:
ACCTS PAYABLE
OKLAHOMA STATE DEPT OF HEALTH
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

PLEASE REVIEW IMPORTANT TERMS & CONDITIONS ON THE REVERSE SIDE OF THIS INVOICE

Order	Shipped	Item Number	Description	Unit	Unit Price	Amount
1	1	220-4716	Inspiron 5000,Pentium III 650 w/SpeedStep,15.0"Super XGA+	EA	2,807.00	2,807.00
1	1	310-0400	Leather Case,15.4",Inspiron, Factory Install	EA	0.00	0.00
1	1	310-4044	Setup Video,Inspiron 5000, English,Factory Install	EA	0.00	0.00
1	1	311-4051	64MB,1 DIMM,100M,4K,Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	313-4651	Modem,56K,Internal,Inspiron 5000 Notebooks,Factory Install	EA	0.00	0.00
1	1	313-4652	24X,12.7MM,Internal,Notebook, Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	320-0256	ATI 8MB Video Card for Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	340-3651	6.0GB 9.5MM,Hard Drive For Dell Inspiron 5000 Notebooks, Factory Install	EA	0.00	0.00
1	1	412-5165	STO-Online Video,OEM,English, No Media,Factory Install	EA	0.00	0.00
1	1	412-5620	Norton Antivirus 2000, version 5.0 with CD & Documentation, English,Factory Install	EA	0.00	0.00
1	1	412-5933	Spire 2.0,No Media,OEM,English	EA	0.00	0.00

MT

* Service contract may be subject to sales tax.
Any on-site or other service covers Dell system hardware only.
PLEASE KEEP THE ORIGINAL BOX FOR ALL RETURNS.

Ship. &/or Handling	$	0.00
Subtotal	$	2,807.00
Taxable: $ 0.00	Tax: $	0.00
Invoice Total	$	2,807.00

DELL

DETACH AT PERF AND RETURN WITH PAYMENT

Invoice Number: 383798832
Customer Number: 003844418
Purchase Order: T075677

MAKE CHECK PAYABLE/REMIT TO:

DELL MARKETING L.P.
PO BOX 120001
DEPT. 0747
DALLAS TX 75312-0747

Ship. &/or Handling	$	0.00
Subtotal	$	2,807.00
Taxable: $ 0.00	Tax: $	0.00
Invoice Total	$	2,807.00
	$	
	$	
	$	
Balance Due	$	2,807.00
Amt. Enclosed	$	

000383798832000000028070084000384441 88

DELL

This is your **INVOICE**

COPY

FID Number: 74-2616805
Sales Rep: JORDAN HAGUE
For Sales: (800)274-7799
Sales Fax: (800)433-9527
Customer Service: (800)981-3355
Technical Support: (800)981-3355
Dell Online: http://www.dell.com

Customer Number: 003844418
Purchase Order: T075677
Order Date: 06/04/00

84 01 O 01 03 N

Invoice Number: 383798832

Invoice Date: 06/06/00
Payment Terms: NET DUE 30 DAYS
Shipped Via:
Waybill Number: 078785106554107

SOLD TO:

2204-10.58-69869F13.XRX 40 of 48

ACCTS PAYABLE
OK DEPT OF HEALTH
FINANCIAL MANAGEMENT
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

SHIP TO:

ACCTS PAYABLE
OKLAHOMA STATE DEPT OF HEALTH
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

PLEASE REVIEW IMPORTANT TERMS & CONDITIONS ON THE REVERSE SIDE OF THIS INVOICE

Order	Shipped	Item Number	Description	Unit	Unit Price	Amount
1	1	420-0420	Windows'98,Second Edition, English,Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	430-2082	Xircom 10/100 Ethernet II PC Card,Factory Install	EA	0.00	0.00
1	1	900-5590	*Type 3 Contract - Next Business Day PartsLabor On-Site Response Initial Year	EA	0.00	0.00
1	1	900-5592	*Type 3 Contract - Next Business Day PartsLabor On-Site Response 2YR Extended	EA	0.00	0.00
1	1	412-4647	MS Office,Pro 2000,CD,With Doc US English,Inspiron,OEM Package,Factory Install	EA	0.00	0.00
1	1	412-7365	MS Office Internet Explorer 5.0 For Office 2K Apps Only, US,English,Factory Install	EA	0.00	0.00

System Service Tags 6USZN

DELL

This is your **INVOICE**

COPY

FID Number: 74-2616805
Sales Rep: JORDAN HAGUE
For Sales: (800)274-7799
Sales Fax: (800)433-9527
Customer Service: (800)981-3355
Technical Support: (800)981-3355
Dell Online: http://www.dell.com

Customer Number: 003844418
Purchase Order: T075677
Order Date: 06/04/00

84 01 O 01 03 N

Invoice Number: 383798832

Invoice Date: 06/06/00
Payment Terms: NET DUE 30 DAYS
Shipped Via:
Waybill Number: 078785106554107

SOLD TO:

2204-10.58-69869F13.XRX 41 of 48

ACCTS PAYABLE
OK DEPT OF HEALTH
FINANCIAL MANAGEMENT
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

SHIP TO:

ACCTS PAYABLE
OKLAHOMA STATE DEPT OF HEALTH
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

PLEASE REVIEW IMPORTANT TERMS & CONDITIONS ON THE REVERSE SIDE OF THIS INVOICE

Order	Shipped	Item Number	Description	Unit	Unit Price	Amount
1	1	220-4716	Inspiron 5000,Pentium III 650 w/SpeedStep,15.0"Super XGA+	EA	2,807.00	2,807.00
1	1	310-0400	Leather Case,15.4",Inspiron, Factory Install	EA	0.00	0.00
1	1	310-4044	Setup Video,Inspiron 5000, English,Factory Install	EA	0.00	0.00
1	1	311-4051	64MB,1 DIMM,100M,4K,Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	313-4651	Modem,56K,Internal,Inspiron 5000 Notebooks,Factory Install	EA	0.00	0.00
1	1	313-4652	24X,12.7MM,Internal,Notebook, Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	320-0256	ATI 8MB Video Card for Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	340-3651	6.0GB 9.5MM,Hard Drive For Dell Inspiron 5000 Notebooks, Factory Install	EA	0.00	0.00
1	1	412-5165	STO-Online Video,OEM,English, No Media,Factory Install	EA	0.00	0.00
1	1	412-5620	Norton Antivirus 2000, version 5.0 with CD & Documentation, English,Factory Install	EA	0.00	0.00
1	1	412-5933	Spire 2.0,No Media,OEM,English	EA	0.00	0.00

* Service contract may be subject to sales tax.
Any on-site or other service covers Dell system hardware only.
PLEASE KEEP THE ORIGINAL BOX FOR ALL RETURNS.

Ship. &/or Handling	$	0.00
Subtotal	$	2,807.00
Taxable: $ 0.00	Tax: $	0.00
Invoice Total	$	2,807.00

DELL

DETACH AT PERF AND RETURN WITH PAYMENT

Invoice Number: 383798832
Customer Number: 003844418
Purchase Order: T075677

MAKE CHECK PAYABLE/REMIT TO:

DELL MARKETING L.P.
PO BOX 120001
DEPT. 0747
DALLAS TX 75312-0747

Ship. &/or Handling	$	0.00
Subtotal	$	2,807.00
Taxable: $ 0.00	Tax: $	0.00
Invoice Total	$	2,807.00
	$	
	$	
	$	
Balance Due	$	2,807.00
Amt. Enclosed	$	

00038379883200000002807008400038444188

DELL

This is your **INVOICE**

COPY

FID Number: 74-2616805
Sales Rep: JORDAN HAGUE
For Sales: (800)274-7799
Sales Fax: (800)433-9527
Customer Service: (800)981-3355
Technical Support: (800)981-3355
Dell Online: http://www.dell.com

Customer Number: 003844418
Purchase Order: T075677
Order Date: 06/04/00

84 01 O 01 03 N

Invoice Number: 383798832

Invoice Date: 06/06/00
Payment Terms: NET DUE 30 DAYS
Shipped Via:
Waybill Number: 078785106554167

SOLD TO:

2204-10.58-69869F13.XRX 42 of 48

ACCTS PAYABLE
OK DEPT OF HEALTH
FINANCIAL MANAGEMENT
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

SHIP TO:

ACCTS PAYABLE
OKLAHOMA STATE DEPT OF HEALTH
1000 N E 10TH ST
OKLAHOMA CITY OK 73117-1299

PLEASE REVIEW IMPORTANT TERMS & CONDITIONS ON THE REVERSE SIDE OF THIS INVOICE

Order	Shipped	Item Number	Description	Unit	Unit Price	Amount
1	1	420-0420	Windows'98,Second Edition, English,Inspiron 5000,Factory Install	EA	0.00	0.00
1	1	430-2082	Xircom 10/100 Ethernet II PC Card,Factory Install	EA	0.00	0.00
1	1	900-5590	*Type 3 Contract - Next Business Day PartsLabor On-Site Response Initial Year	EA	0.00	0.00
1	1	900-5592	*Type 3 Contract - Next Business Day PartsLabor On-Site Response 2YR Extended	EA	0.00	0.00
1	1	412-4647	MS Office,Pro 2000,CD,With Doc US English,Inspiron,OEM Package,Factory Install	EA	0.00	0.00
1	1	412-7365	MS Office Internet Explorer 5.0 For Office 2K Apps Only, US,English,Factory Install	EA	0.00	0.00

System Service Tags 6USZN

DELL

Dell Computer Corporation
8801 Research Blvd.
Austin, Texas 78758

Sales: (800) 274-3355
Customer Service: (800) 274-1140
Fax: (800) 333-4329
www.dell.com

PACKING SLIP

SHIP TO: ATTN:
PHONE #: 4052714727
ACCTS PAYABLE
OKLAHOMA STATE DEPT OF HEALTH
1000 N E 10TH ST
OKLAHOMA CITY, OK
731171299

SOLD TO: ACCTS PAYABLE
1000 N E 10TH ST
OKLAHOMA CITY, OK
731171299

Customer Acct	Customer Purchase Order Number	Salesperson Name-Company No.	Order No.
3844418	T075677	JORDAN HAGUE	383798832

Date	Order Date	Shipped Via	Tracking/Bill of Lading No.
6/6/2000	6/4/2000	RPS	078785106554107

ORDERED	QUANTITY SHIPPED	ITEM NUMBER	DESCRIPTION	PART #	UNIT
1	1	220-4716	Inspiron 5000,Pentium III 650 w/SpeedStep,15.0"Super XGA+ 6USZN - 20000222	3138U	EA
1	1	310-0400	Leather Case,15.4",Inspiron, Factory Install	6509T	EA
1	1	310-4044	Setup Video,Inspiron 5000, English,Factory Install	6138U	EA
1	1	311-4051	64MB,1 DIMM,100M,4K,Inspiron 5000,Factory Install	1837U	EA
1	1	313-4651	Modem,56K,Internal,Inspiron 5000 Notebooks,Factory Install	8758U	EA
1	1	313-4652	24X,12.7MM,Internal,Notebook, Inspiron 5000,Factory Install	6928U	EA
1	1	320-0256	ATI 8MB Video Card for Inspiron 5000,Factory Install	9937U	EA
1	1	340-3651	6.0GB 9.5MM,Hard Drive For Dell Inspiron 5000 Notebooks, Factory Install	57JEV	EA
1	1	412-5165	STO-Online Video,OEM,English, No Media,Factory Install	69VRM	EA
1	1	412-5620	Norton Antivirus 2000, version 5.0 with CD & Documentation, English,Factory Install	562DP	EA
1	1	412-5933	Spire 2.0,No Media,OEM,English	401XH	EA
1	1	420-0420	Windows'98,Second Edition, English,Inspiron 5000,Factory Install	4678U	EA
1	1	430-2082	Xircom 10/100 Ethernet II PC Card,Factory Install	8516U	EA
1	1	900-5590	Type 3 Contract - Next Business Day PartsLabor On-Site Respon Initial Year	3872E	EA
1	1	900-5592	Type 3 Contract - Next Business Day PartsLabor On-Site Respon 2YR Extended	3872E	EA
1	1	412-4647	MS Office,Pro 2000,CD,With Doc US English,Inspiron,OEM Package,Factory Install	7041T	EA
1	1	412-7365	MS Office Internet Explorer 5.0 For Office 2K Apps Only, US,English,Factory Install	9858R	EA

RECEIVED
JUN 07 2000
SHIPPING & RECEIVING

SHIP TO: OTTAWA CHD
SUSAN WALDRON
1930 N. ELM
MIAMI, OK 74354

TOTAL WT.	TOTAL PIECES
16.4375	1

w returns, see Dell's 'Total Satisfaction Return Policy'. Contact Customer Service for an authorization number.

LINDA WILSON

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T074364	034764

FOR AGENCY USE
WARRANT # 8069899 DATE: 05/18/2000

CLAIM OF:
G I TECH INC
112922333

0
3
4
7
6
4

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	88042	4112	841810000	226.32

FOR
$ 226.32

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		226.32

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000504

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
04/28/2000	A6558	226.32

THIS SPACE FOR AGENCY USE

400BT00 000035NW0A 4112AAAAAX 226.32

J/E XREF:

VENDOR: G I TECH INC
ADDRESS: 469 ATLANTIC AVE
ADDRESS:
CITY/ST/ZIP: EAST ROCKAWAY NY 11518

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

05/16/2000

Title Date

Agency, Bd or Div. Use

037464

GI Tech, Inc.

469 Atlantic Avenue
East Rockaway, NY 11518
Tel: (516) 593-1515 Fax: (516) 593-7884
WWW.GI-TECH.COM

*** I N V O I C E *** **NO: A 6558** **DATE: 04/28/00**

* BILL TO *	* SHIP TO *
OKLAHOMA STATE DEPT. OF HEALTH ATTN: ACCOUNTS PAYABLE 1000 N.E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	SAME ATTN: PO# T074364

CUS-NO	CUS-P/O-NO	SLSM	SHIP-VIA	SHIPPED-ON	REF-NO	TERMS
AOKSDH	T074364	ZZ	UPS	04/28/00	A 5558	NET 30

QUANTITY	ITEM-NUMBER	DESCRIPTION	UNIT-PRICE	EXTENSION
3	IOM10597	IOMEGA JAZ 2GB PC CARTRIDGE	75.44	226.32
			SUB TOTAL	226.32

112922333
400BT00
000035NWØA
88042
~~4413~~

RECEIVED
2000 MAY -9 P 3:08
FINANCIAL MANAGEMENT

9 5.12.00

INVOICE TOTAL 226.32

THANK YOU FOR YOUR BUSINESS

AP 5/11/0

GI Tech, Inc.

469 Atlantic Avenue
East Rockaway, NY 11518
Tel: (516) 593-1515 Fax: (516) 593-7884
WWW.GI-TECH.COM

* P A C K I N G L I S T *

NO: A 6558 DATE: 04/28/00

* BILL TO *	* SHIP TO *
OKLAHOMA STATE DEPT. OF HEALTH ATTN: ACCOUNTS PAYABLE 1000 N.E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	SAME ATTN: PO# T074364

CUS-NO	CUS-P/O-NO	SLSM	SHIP-VIA	SHIPPED-ON	REF-NO	TERMS
AOKSDH	T074364	ZZ	UPS	04/28/00	A 5558	NET 30

QUANTITY	ITEM-NUMBER	DESCRIPTION
3	IOM10597	IOMEGA JAZ 2GB PC CARTRIDGE

N Powell 5-5-00

THANK YOU FOR YOUR BUSINESS

RECEIVED
MAY 04 2000
SHIPPING & RECEIVING

LINDA WILSON - 4470

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T039066	017591

FOR AGENCY USE
WARRANT # 7551675 DATE: 12/15/1999

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	88042	4112	939400000	3,712.00

CLAIM OF:
GATEWAY COMPANIES, INC
460431398

0 1 7 5 9 1

FOR
$ 3,712.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	3,712.00
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/19/1999	75244684	3,712.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW0A 411210326X 3712.00

J/E XREF:

VENDOR: GATEWAY COMPANIES, INC.
ADDRESS: PO BOX 41033
ADDRESS:
CITY/ST/ZIP: SANTA ANA CA 927991033

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

_____
Agency's Approving Officer

01759

Gateway

Gateway Companies, Inc.
610 Gateway Drive
North Sioux City SD 57049
Tel: 800-846-2000
Fax: 605-232-2718

Gateway Companies Inc.
P.O. Box 41033
Santa Ana CA 92799-1033

Date	Invoice #	Client P.O.	Client I.D.	Sales Representative
11/19/99	75244684	T039066 H60 431 398	15081221	8939

Payment Terms	Ship Via	Gateway Order #	Order Date
SEE BELOW	UPS Multi-Unit Delivery	41686979	11/16/99

PO#T039066

Oklahoma State Dept of Health
Attn: Accts Payable
1000 NE 10th St
OKLAHOMA CITY OK 731171299

PO#T039066
Oklahoma State Dept of Health
Attn: Shipping & Receiving
1000 NE 10th St
OKLAHOMA CITY OK 731171299

I N V O I C E

Qty - Item # / Description		System Serial #	Unit Price	Amount
2 1002601	Shipped		1526.00	3052.00
E-4200 550 PC				
Serial Numbers for item 1002601		0016321045		
		0016321046		
2 7001580	Shipped		300.00	600.00
EV700 17" Monitor with 15.9" Viewable				
2 7001333	Shipped		30.00	60.00
GCS200 Speakers by Cambridge SoundWorks				
2 1508982	Shipped			INCLUDED
3Yr Part/3Yr Labor/3Yr Onsite/Own-It HW & SW Phone Support				
Sales Tax				.00

Payment Term
Net 30 T039066 3712.00

Please remit payment for the full amount of this invoice within 30 days. Balances after 30 days will be considered deliquent.
** Please note corrected REMIT TO information. **

Correct FEIN is 46-0431398.
Not subject to backup withholding.

The amounts shown on this document reflect U.S. Dollar

400 BTOO
000035NW01
88042
4112103261X

Purchase Sub-Total	Sales Tax	Freight & Handling		
3712.00	.00	.00	TOTAL ➡	3712.00

Tax Rt
099323

Page # 1

Remit To: *Please return this portion with your payment. Disregard this notice if payment has been made.*

Gateway Companies Inc.
P.O. Box 41033
Santa Ana CA 92799-1033
Tel: 800-846-2000
Fax: 605-232-2718

Client ID	Invoice Date	Invoice #	Total
15081221	11/19/99	75244684	3712.00

12-9-99 dl

11/30/99

Gateway

610 Gateway Drive
North Sioux City, South Dakota 57049

If you have any questions please contact our
Customer Service Department at 800-846-2000
Fax 605-232-2023
7 a.m. to 10 p.m. Monday through Friday (Central Time)
9 a.m. to 4 p.m. Saturday (Central Time)

PACKING SLIP

Client P.O.	Order Date	Ship Date	Client I.D.	Order #	Sales Representative
T039066	11/16/99	11/19/99	15081221	41686979	EUS005849

GATEWAY USE ONLY

Client Contact	# of Boxes	Terms	Ship Via
		A03	UPS Multi-Unit Delivery

SHIP TO
(405) 271-4043
Oklahoma State Dept of Health
Attn: Shipping & Receiving
1000 NE 10th St
OKLAHOMA CITY OK 731171299

SOLD TO
Oklahoma State Dept of Health
Attn: Accts Payable
1000 NE 10th St
OKLAHOMA CITY OK 731171299

Item #	Qty		Description	Serial #
1.000	2	2	1002601	0016321045
			E-4200 550 PC	990569
			0016321046 — 990570	
1.001	2	2	Mid-Tower Case	
1.004	2	2	7001580	
			EV700 17" Monitor with 15.9" Viewable	
1.011	2	2	7001333	
			GCS200 Speakers by Cambridge SoundWorks	
1.016	2	2	1508982	
			3Yr Part/3Yr Labor/3Yr Onsite/Own-It HW & SW Phone Support	
1.020	2	2	9505035	
			Separate Accessory Box	
1.027	2	2	9501897	
			NSK DISCOUNT-STATE CONTRACT R0	
1.002	2	2	Motherboard with Intel 550MHz Pentium III Processor	
1.003	2	2	128MB Memory Module	
1.005	2	2	ATI RAGE 128VR 8MB AGP Video Card	
1.006	2	2	Fat 32 for Windows 95 or 98 (Download only)	
1.007	2	2	13.6GB 5400RPM Ultra ATA Hard Drive	
1.008	2	2	17.5x Minimum/40x Maxium IDE CD-ROM	
1.009	2	2	3.5" 1.44 MB Floppy Diskette Drive	
1.010	2	2	SoundBlaster AudioPCI 128D	
1.012	2	2	104 Key Keyboard	
1.013	2	2	Microsoft Intellimouse	
1.014	2	2	3Com 10/100 PCI Network Card with Wake-on LAN Cable	
1.015	2	2	Microsoft Windows 98 Second Edition	
1.017	2	2	Gateway Restoration CD	
1.018	2	2	Norton Anti-Virus	
1.019	2	2	Manuals	

John T. Burger

RECEIVED
NOV 23 1999
SHIPPING & RECEIVING

598 4D LASER PACK SLIP

Page #

LINDA 4470

Gateway

610 Gateway Drive
North Sioux City, South Dakota 57049

If you have any questions please contact our
Customer Service Department at 800-846-2000
Fax 605-232-2023
7 a.m. to 10 p.m. Monday through Friday (Central Time)
9 a.m. to 4 p.m. Saturday (Central Time)

PACKING SLIP

Client P.O.	Order Date	Ship Date	Client I.D.	Order #	Sales Representative
T039066	11/16/99	11/19/99	15081221	41686979	EUS005849

GATEWAY USE ONLY

Client Contact	# of Boxes	Terms	Ship Via
		A03	UPS Multi-Unit Delivery

SHIP TO
(405) 271-4043
Oklahoma State Dept of Health
Attn: Shipping & Receiving
1000 NE 10th St
OKLAHOMA CITY OK 731171299

SOLD TO
Oklahoma State Dept of Health
Attn: Accts Payable
1000 NE 10th St
OKLAHOMA CITY OK 731171299

Box		Item #	Description	Serial #
1.021	2	1	Bezel Label	
1.022	2	2	Pentium III AirDuct	
1.023	2	2	LANdesk Client Manager Software	

WE ARE CONFIDENT IN THE QUALITY OF OUR COMPUTERS AND THE ACCESSORY PRODUCTS WHICH ACCOMPANY IT. PLEASE CHECK THE CONTENTS OF YOUR PACKAGE(S) IMMEDIATELY AGAINST YOUR PACKING SLIP. IF FOR SOME REASON YOU DID NOT RECEIVE PART OF YOUR ORDER, YOU MUST CONTACT CUSTOMER SERVICE WITHIN 30 DAYS AFTER YOU HAVE ACCEPTED RECEIPT OF YOUR COMPUTER AND ACCESSORY PRODUCTS.

RECEIVED
NOV 2 3 1999
SHIPPING & RECEIVING

5/98 #3 LASER PACK SLIP

*** END OF PACK ***

Time And Effort Cost
Cost Accumulation Schedule

December 27, 2000
Prepared By _____

Grant Name: Conduct Site Specific Activity
Grant Number U50 / ATU686520-02
Grant Period 09/29/1999 TO 09/28/2000
Program Code 391

[redacted]

YearMonth	FEES	TRAVEL	EQUIP	OTHER
199910	29.95	68.29	0.00	314.40
199911	33.83	113.54	0.00	460.20
199912	57.01	111.23	0.00	365.45
200001	82.48	85.09	0.00	570.89
200002	80.00	113.40	0.00	563.74
200003	49.32	90.19	0.00	448.55
200004	37.03	56.69	0.00	288.52
200005	48.98	95.39	0.00	399.42
200006	54.81	75.95	0.00	577.69
200007	55.18	23.25	0.00	259.16
200008	60.18	65.22	0.00	661.65
200009	49.33	93.79	0.00	461.43
Total	**638.10**	**991.03**	**0.00**	**5,371.10**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

YearMonth	FEES	TRAVEL	EQUIP	OTHER
199910	4.17	9.51	0.00	43.76
199911	3.43	11.53	0.00	46.73
199912	6.65	12.97	0.00	42.62
200001	12.24	12.63	0.00	84.73
200002	8.67	12.29	0.00	61.10
200003	5.38	9.83	0.00	48.90
200004	4.02	6.04	0.00	31.30
200005	5.67	11.03	0.00	46.21
200006	5.62	7.79	0.00	59.24
200007	5.62	2.45	0.00	27.34
200008	6.13	6.65	0.00	67.44
200009	5.34	10.15	0.00	49.96
Total	**73.14**	**112.87**	**0.00**	**669.33**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
34.12	77.80	0.00	358.16
37.26	125.07	0.00	506.93
63.66	124.20	0.00	408.07
94.72	97.72	0.00	655.62
88.67	125.69	0.00	624.84
54.70	100.02	0.00	497.45
41.05	61.73	0.00	319.82
54.65	106.42	0.00	445.63
60.43	83.74	0.00	636.93
61.00	25.70	0.00	286.50
66.31	71.67	0.00	729.09
54.67	103.94	0.00	511.39
711.24	**1,163.96**	[redacted]	**5,990.43**

OTHER

9/29/1999 to 9/28/2000

Claims	23,055.18
PROGCOST - Other	5,980.43
Worker's Comp.	1,636.73
Total Other	$ 30,672.34

Claims are the direct costs and PROGCOST are the allocated costs. These costs are for things like office supplies and test kits for blood lead. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T076691	034713

FOR AGENCY USE WARRANT # 8069850 DATE: 05/18/2000

CLAIM OF:
SOUTH CENTRAL INDUSTRIES, INC
731138726 0 3 4 7 1 3

FOR $ 49.50

AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3721	932000000	50.00

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		49.50

OSF-AUDITED BY

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR) NO.

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/04/2000	1941	49.50

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3721AAAAAX 50.00

J/E XREF: 063931

VENDOR: SOUTH CENTRAL INDUSTRIES, INC
ADDRESS: 130 N. LOUISE
ADDRESS:
CITY/ST/ZIP: SHAWNEE OK 748023766

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

05/16/2000

Title Date

Agency, Bd or Div. Use

034713

SOUTH CENTRAL INDUSTRIES, INC.
P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer's Order No. T076691 Phone No. ..... Date 5-4-00

Name OK State Dept of Health

Address 1000 N.E 10th Street OKC, OK 73117

SOLD BY	CASH	C.O.D.	CHARGE		

Quantity	DESCRIPTION		AMOUNT
1cs	0475-41-44-150	50.00	50.00
	Latex PF medium Ellice		
	100/box 10 box/case		
	Thank You!		
			50.00
	Minus 1% Tax		.50
		TOTAL	[illegible]

ALL claims and returned goods MUST [illegible]

Rec'd by EWORD

1941

Thank You

RECEIVED
MAY 0 4 2000
SHIPPING & RECEIVING

Ship to: Ottawa County Health Department
Attn: Susan Waldron
1930 N Elm St.
Miami, OK 74354

5-12-00

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T073296	034155

FOR AGENCY USE WARRANT # 8059846 DATE: 05/16/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3721	932000000	7,150.00
000035	42000	3111	932000000	25.00

CLAIM OF:
ESA, INC
042447948

0341155

FOR
$ 7,175.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		7,175.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
04/19/2000	567909/56821	7,175.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3721AAAAAX 7150.00
400BT00 000035NW97 3111AAAAAX 25.00

J/E XREF:

VENDOR: ESA, INC
ADDRESS: 22 ALPHA RD
ADDRESS:
CITY/ST/ZIP: CHELMSFORD MA 018244171

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 05/11/2000

Title Date

Agency, Bd or Div. Use

	Date	Number
INVOICE	4/19/00	567909/568212
SALES ORDER		215337/215445

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Ship Via UPS
F.O.B. FACTORY
Ship Term
Bill of Lading

034155

Bill To:
10565 OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10th STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
OKLAHOMA STATEDEPARTMENT OF
OTTAWA COUNTY HEALTH DEPT.
ATTN: SUSAN WALDRON
1930 N. ELM STREET
OKLAHOMA CITY, OK 74354

KEN CADARET 405-271-4892
PLEASE SHIP LONGERT EXPIRATION DATES AVAILABLE!!! lc

Payment Terms	Sales REp # 36	Customer PO
NET 30		T073296

Line	Qty	Part Number	Description	Unit Price	Value
1	30	70-3333	LEADCARE BLOOD LEAD TEST KIT	$230.00	$6,900.00
2	10	70-3440	LEADCARE CONTROL KIT	25.00	250.00

[redacted]

042447948

T073296 000035NW97
FX 001 400 BT00
142009 3721 A-x 7,150.00
3111 A-x 25.00
SJF 5-10-00
INVOICE APPROVED DATE 10:13 per Ken Cadaret

RECEIVED

Sale Amount	$7,150.00
Freight	25.00
TOTAL	$7,175.00

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

[redacted]

Ship Via UPS
F.O.B. FACTORY
Ship Term
Bill of Lading

COPY

[redacted]

KEN CADARET 405-271-4892
PLEASE SHIP LONGEST EXPIRATION DATES AVAILABLE!!! lc

Payment Terms
NET 30

Sales REp # 36

Customer PO
[redacted]

[redacted]

1	30	70-[illegible]93	LEADCARE BLOOD LEAD TEST KIT	$230.00	$6,900.00
2	10	7[illegible]	LEADCARE CONTROL KIT	25.00	250.00

Patrick,
Please file
this w/ Clm
#034155
Thanks

042449 48

RECEIVED
2000 MAY 11 A 10:40
FINANCIAL MANAGEMENT

7073296 PURCHASE DOCUMENT	V00035AM97 ACCOUNT NO.
X COMPLETE	001 PARTIAL
400 BT00 FUND NO.	
43000 MATH CHECKED	3721 A-X OBJECT CODE 7,150.00
CLAIM ENTERED	3111 A-X CLAIM NUMBER 25.00
INVOICE APPROVED	5-10-00 DATE

per Ken Cadaret

[redacted]

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T063211	029871

FOR AGENCY USE
WARRANT # 7914686 DATE: 04/04/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3721	939190000	494.50

CLAIM OF:
THOMAS SCIENTIFIC
223336902

0 2 9 8 7 1

FOR
$ 494.50

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		494.50

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000331

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/07/2000	20000671039	494.50

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3721AAAAAX 494.50

J/E XREF:

VENDOR: THOMAS SCIENTIFIC
ADDRESS: P.O. BOX 99
ADDRESS:
CITY/ST/ZIP: SWEDESBORO NJ 080850099

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/31/2000

Title Date

Agency, Bd or Div. Use

THOMAS SCIENTIFIC®
Helping science create a better world

99 High Hill Road at I-295 • Box 99 • Swedesboro, NJ 08085-0099 U.S.
Telephone: 609 467-2000 • Federal Identification No. 22-3336902

NEW TELEPHONE : (856) 467 - 2000 0637

Order No./Req. No.	Invoice No.	Invoice Date	F.O.B.
T063211	20000671039	03-07-2000	4

Account No.: 36-5280000 .0000 042

Terms: Net 30 Days. A service charge of 1% on past due invoices will be added. Minimum charge .50

Zone: 6R

BILL TO:
OKLAHOMA STATE DEPT HEALTH
ACCOUNTS PAYABLE
1000 NE 10TH STREET
OKLAHOMA CITY OK 73117

SHIP TO:
OTTAWA COUNTY HEALTH DEPT
ATTN SUSAN WALDRON
1930 NORTH ELM
MIAMI OK 74354

ACCOUNT CONDITIONS
CERTIFIED STAMP

DATE ORDER RECEIVED: 03-07-2000

PLEASE RETURN 3RD COPY WITH YOUR REMITTANCE

029871 PR

223 336902

ITEM NO.	QUAN.	U/M	CATALOG NO.	OLD CATALOG NO.	DESCRIPTION	UNIT PRICE	AMOUNT
1	5	CT	1951-M13	M28E04	RUBBER BULB. CT 144	98.90	494.
					SUB TOTAL		494.
					FREIGHT		
					PAY THIS AMOUNT		494.

RECEIVED
MAR 31 2000
FINANCIAL MANAGEMENT

400BT00
000035NW97
42000
3721A -X

DUPLICATE INVOICE
Arthur H. Thomas Company

MERCHANDISE MENTIONED HEREON HAS BEEN MANUFACTURED IN ACCORDANCE WITH THE U.S. FAIR LABOR STANDARDS ACT, AS AMENDED. THESE COMMODITIES LICENSED BY U.S.A. DIVERSION CONTRARY TO U.S.A. LAW PROHIBITED.

THOMAS SCIENTIFIC®
Helping science create a better world

99 HIGH HILL ROAD at I-295 • P.O. BOX 99 • SWEDESBORO, NJ 08085-0099 US.
TELEPHONE: 856-467-2000 • FAX: 856-467-3087
INTERNET: www.thomassci.com • E-MAIL: value@thomassci.com

ACCOUNT NO.	ORDER NO. / REQUISITION NO.	[redacted]	DATE ORDERED	STATE TAX	COUNTY TAX	CITY TAX	TERRITO
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

SHIP TO

[redacted]

ITEM NO.	[redacted]	QTY. BACK ORD.	U/M	[redacted]	DESCRIPTION
[redacted]	[redacted]		CT	[redacted]	[redacted]

PACKING LIST

RECEIVED
MAR 2 3 2000
Personal Health Finance
3/13/00
Rcd

CHECK FOR DAMAGE IN TRANSIT

IT IS IMPORTANT TO FOLLOW THE PROCEDURES BELOW

MOTOR FREIGHT, FREIGHT FORWARDER OR AIR SHIPMENTS

1. Check the shipment upon delivery and note any damage or shortage on the delivery receipt. Make certain to sign and have the carrier driver sign the delivery receipt as well.
2. **DO NOT** refuse damaged merchandise.
3. Keep the shipping carton, packing material and merchandise for carrier inspection and until satisfactory adjustment is made.
4. Call the delivery carrier immediately for an investigation, follow up with a confirming letter.
5. Claims must be made within 10 days of the date of delivery.

PARCEL POST, UNITED PARCEL SERVICE SHIPMENTS

1. Call Thomas Scientific immediately. Refer to your order number and our invoice number for shipment.
2. Keep damaged goods and shipping container for instructions from Thomas.

DO NOT RETURN GOODS WITHOUT A RETURN GOODS AUTHORIZATION NUMBER

MATERIALS RETURNED WHERE NO ERROR ON OUR PART EXISTS, WILL BE SUBJECT TO HANDLING AND RESTOCKING CHARGES.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T058030	026453

FOR AGENCY USE
WARRANT # 7827020 DATE: 03/09/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3125	000000000	400.00

CLAIM OF:
HCFA LABORATORY PROGRAM
520883104

0 2 6 4 5 3

FOR
$ 400.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		400.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/14/2000	37D0968929	400.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3125AAAAAX 400.00

J/E XREF:

VENDOR: HCFA LABORATORY PROGRAM
ADDRESS: PO BOX 105422
ADDRESS:
CITY/ST/ZIP: ATLANTA GA 303485422

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/03/2000

Title Date

Agency, Bd or Div. Use

026453

RECEIVED

MAR 01 REC'D

FINANCIAL MANAGEMENT

CLIA USER FEE REMITTANCE
(SEE BACK OF FORM FOR SPECIAL INSTRUCTIONS)

CLIA IDENTIFICATION NUMBER	CERTIFICATE DUE	COMPLIANCE DETERMINATION DUE	ADJUSTMENT DUE	TOTAL DUE
37D0968929	100.00	300.00	.00	400.00

Pay

ACTIVITY: 12

DATE DUE: 02/14/2000

255

NAME AND ADDRESS OF LABORATORY

OTTAWA COUNTY HEALTH DEPARTMENT
1930 N ELM
MIAMI OK 74354-0000

INDICATE ANY CHANGES IN NAME OR ADDRESS

FORM HCFA-35 (5-93)

7058030 PURCHASE DOCUMENT
000035 NW97 ACCOUNT NO.
COMPLETE PARTIAL
FUND NO. 400BT00
PR-42000 MATH CHECKED
3125 A-X OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
INVOICE APPROVED
2-24-00 DATE

RECEIVED
FEB 28 2000
Personal Health Finance

0968929000000000009912290000100000000300000000400000

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T043324	023843

FOR AGENCY USE
WARRANT # 7741422 DATE: 02/14/2000

CLAIM OF:
ESA, INC
042447948

0
2
3
8
4
3

FOR
$ 6,181.60

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3721	932000000	6,155.00
000035	42000	3111	932000000	26.60

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	6,181.60
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000111

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/30/1999	565517	6,181.60

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3721AAAAAX 6155.00
400BT00 000035NW97 3111AAAAAX 26.60

J/E XREF:

VENDOR: ESA, INC
ADDRESS: 22 ALPHA RD
ADDRESS:
CITY/ST/ZIP: CHELMSFORD MA 018244171

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 02/09/2000

Title Date

Agency, Bd or Div. Use

	Date	Number
INVOICE	11/30/99	565517
Sales Order	11/30/99	213160

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Ship Via ASAP/GROUND
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
C/O OTTAWA COUNTY HEALTH
SUSAN WALDRON
1930 N. ELM STREET
MIAMI, OK 74354

NOTE: SHIPPING ADDRESS!!!!KEN CADARET 405-271-4470
PLEASE SHIP ASAP GROUND
LC
072 447948

Payment Terms NET 30 | Sales Rep # 36 | Cust PO T043324

Line	Qty	Part Number	Description	Unit Price	Value
1	25	70-2233	LEADCARE BLOOD LEAD TEST KIT	220.0000	5500.00
2	7	70-3440	LEADCARE CONTROL KIT	35.0000	245.00
3	15	70-3663	PLUNGERS BLOOD LEAD COLLECTION	9.0000	135.00
4	15	70-3662	CAPILLARIES BLOOD LEAD COLLECTION	30.0000	450.00

400 BT00
000035NW97
42000
fee credit

3721A-X 6155.00
3111A-X 26.60

Sale Amount	6330.00
Misc Amount	.00
Sales Tax	.00
Freight	26.60
TOTAL	6356.60
	<175.00>

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

	Date	Number
CREDIT MEMO	12/16/99	CM8238
Sales Order	11/30/99	213160

Ship Via ASAP/GROUND
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
C/O OTTAWA COUNTY HEALTH
SUSAN WALDRON
1930 N. ELM STREET
MIAMI, OK 74354

NOTE: SHIPPING ADDRESS!!!!KEN CADARET 405-271-4470
PLEASE SHIP ASAP GROUND
LC

Sales Rep # 36 Cust PO T043324

Line	Qty	Part Number	Description	Unit Price	Value
900		Deduction 507	DOMESTIC LEADCARE REAGENTS/SEN	(	175.00

Sale Amount	.00
Misc Amount	175.00
Sales Tax	.00
Freight	.00
Credit	175.00

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Sales Order
PICK LIST 11/30/99 213160
Order 11/30/99

Ship Via ASAP/GROUND
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
C/O OTTAWA COUNTY HEALTH
SUSAN WALDRON
1930 N. ELM STREET
MIAMI, OK 74354

NOTE: SHIPPING ADDRESS!!!!KEN CADARET 405-271-4470
PLEASE SHIP ASAP GROUND
LC

Payment Terms: NET 30
Sales Rep # 36
Cust PO: T043524

Line	Qty.	U/M	Part Number	Description	Ship Date	Scheduled Qty. Shippe
1 ✓	25	EA	70-2233	AHT		
			LEADCARE BLOOD LEAD TEST KIT		11/30/99	25
			STOCKROOM: MAIN	LOCATION: SHIP		
2 ✓	7	EA	70-3440	LEADCARE CONTROL KIT	11/30/99	7
			STOCKROOM: MAIN	LOCATION: FRIG DC 99/0-06		
3 ✓	15	EA	70-3663			
			PLUNGERS BLOOD LEAD COLLECTION		11/30/99	15
			STOCKROOM: MAIN	LOCATION: BULK10		
4 ✓	15	EA	70-3662			
			CAPILLARIES BLOOD LEAD COLLECTION		11/30/99	15
			STOCKROOM: MAIN	LOCATION: BULK10		

040699

tc PP 12/7/99

RECEIVED
JAN 11 2000
Personal Health Finance

5 Controls sent back for credit 12/7/99

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

OTTAWA COUNTY HEALTH DEPARTMENT
1930 N. ELM STREET
MIAMI, OK 74354-5400 918-540-2481

FAX COVER SHEET
FAX NUMBER: 918-540-2486

****

DATE: 12-7-99 TIME: 9:30

TO: Ken Cadaret

COMPANY OSDH Lead

PHONE NO. _____ FAX NO. 405-271-4892

THIS TRANSMISSION CONSISTS OF 2 PAGES, INCLUDING THIS PAGE. IF YOU DO NOT RECEIVE THE ENTIRE TRANSMISSION, PLEASE CONTACT 918-540-2481.

ASK FOR: _____

MESSAGE: I'm sending 5 scantrols back - here's the + I'll mail you the original

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS LEGALLY PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPY OF THIS FACSIMILE IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS FACSIMILE IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL TO US AT THE ADDRESS ABOVE VIA THE U.S. POSTAL SERVICE.

SIGNED: Nancy Hankins
OTTAWA COUNTY HEALTH DEPARTMENT

Hartzell, Bonnie L.

From: Hartzell, Bonnie L.
Sent: Tuesday, January 25, 2000 1:35 PM
To: Cox-Kain, Julie
Subject: PO T043324 - ESA Inc

I have an invoice for this purchase order. The purchase order has 25.00 for freight. The actual freight is 26.60. Please increase the purchase order (object code 3100) by 1.60.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		018258

FOR AGENCY USE
WARRANT # 7577503 DATE: 12/22/1999

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3721	939190000	102.20

CLAIM OF:
FISHER SCIENTIFIC
232942737

0 1 8 2 5 8

FOR
$ 102.20

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	102.20
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/16/1999	1070357	102.20

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 372108210X 102.20

J/E XREF:

VENDOR: FISHER SCIENTIFIC
ADDRESS: DEPT 525253
ADDRESS: P.O. BOX 360153
CITY/ST/ZIP: PITTSBURG PA 152506153

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

12/16/1999

Title Date

Agency, Bd or Div. Use

U18258 d

Fisher Scientific

REMIT TO:
ACCT# 402313-001
DEPT. CH 10119
PALATINE IL
60055-0119

INQUIRE AT: (800) 766-7000
9999 VETERANS MEMORIAL DR
HOUSTON TX
77038-2499

D-U-N-S-00-432-1519
FEIN 23-2942737
ORIGINAL INVOICE

PLEASE REFER TO THIS INVOICE NUMBER ON YOUR REMITTANCE

1070357

CUSTOMER PURCHASE ORDER NUMBER – RELEASE NUMBER	INV. DATE
T038610 MAIL	11/15/1999

ORDER NO.	ACCOUNT NO.	CSO	F.O.B.	ORDER ENTRY DATE	PAGE	DUPLICATE
H93197123	402313-001	CHO	SHIPPING POINT	11/15/1999	1	

SOLD TO:

STATE OF OKLAHOMA
DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY OK 73117-1299

SHIP TO:

LINDA WILSON/MCH
STATE OF OKLAHOMA
DEPT OF HEALTH
1000 N.E. 10TH
ATTN SHIPPING & RECVG
OKLAHOMA CITY OK 73117-1299

INVOICE TYPE: NOR FON CON

THIS IS A PARTIAL SHIPMENT ☐

DUE: 12/15/1999
TERMS: NET 30 DAYS FROM INVOICE DATE.
PAYABLE IN U.S. CURRENCY.

Visit the Fisher Web Site: WWW.FISHERSCI.COM

DESCRIPTION	CATALOG NUMBER	QUANTITY SHIPPED	UNIT PRICE	AMOUNT
CALLER-PETER HOLLAND PHONE-405-521-2133				
SHIPMENT NBR: 001 FROM: DVR ON: 11/15/1999				
KIMWIPE SML 4-1/2X8-1/2 280/PK	06 666A	1 CS	102.20 ✓	102.20
TOTAL INVOICE AMOUNT				102.20
PLEASE USE REMIT TO ADDRESS ABOVE AND INCLUDE DEPT. NBR.				

400BT00
000035NW97
42000
3721 08210X

LOSF 00049

SEE REVERSE SIDE FOR ADDITIONAL TERMS AND CONDITIONS

PAST DUE BALANCES ARE SUBJECT TO A FINANCE CHARGE. THIS SHIPMENT WAS DELIVERED IN PERFECT CONDITION AND SIGNED FOR BY THE TRANSPORTATION COMPANY. CONSIGNORS RESPONSIBILITY CEASES UPON DELIVERY OF GOODS TO CARRIER. DO NOT ACCEPT SHIPMENT SHOWING EVIDENCE OF DAMAGE OR SHORTAGE UNTIL AGENT OF CARRIER ENDORSES NOTATION TO THIS EFFECT ON FACE OF TRANSPORTATION RECEIPT. WITHOUT THIS DOCUMENTARY EVIDENCE CLAIM CANNOT BE FILED. SELLER CERTIFIES THAT ALL GOODS (OR SERVICES) COVERED BY THIS INVOICE WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTIONS 6, 7, AND 12 OF THE FAIR LABOR STANDARDS ACTS OF 1938, AS AMENDED, AND OF THE REGULATIONS AND ORDERS OF THE UNITED STATES DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF.

NO CREDIT WILL BE ALLOWED FOR MERCHANDISE RETURNED WITHOUT PRIOR AUTHORIZATION.

THE PRICES SHOWN ON THIS INVOICE ARE NET OF DISCOUNTS PROVIDED AT THE TIME OF PURCHASE. SOME PRODUCTS MAY BE SUBJECT TO ADDITIONAL DISCOUNTS AGREED UPON BETWEEN THE PARTIES. SEE REVERSE SIDE FOR DISCOUNT OR PRICE REDUCTION DISCLOSURE REQUIREMENTS.

12-15-99 d

12/7/99

OPEN AND INSPECT IMMEDIATELY
QUESTIONS REGARDING THIS SHIPMENT SHOULD BE DIRECTED TO YOUR CUSTOMER SERVICE OFFICE WITHIN 10 DAYS
AT: 800-766-7000

SHIPMENT DETAIL DOCUMENT

Fisher Scientific

PAGE 1

CUSTOMER SERVICE OFFICE	
FHC HOUSTON	
SHIP VIA: DVR	ORDER NO.: H93197123-001

PLEASE REFERENCE THE ORDER NUMBER SHOWN ABOVE IN ALL CORRESPONDENCE.
RETURNS WILL NOT BE ACCEPTED WITHOUT PRIOR AUTHORIZATION.

CUSTOMER ACCOUNT NO.	CUSTOMER PURCHASE ORDER NO.
402313-001	T038610
DATE ORDERED: 11/15/99	CUSTOMER REQUISITION/RELEASE NO.: MAIL
CALLER: PETER HOLLAND	CALLER PHONE NO.: (405)521-2133

SOLD TO:
STATE OF OKLAHOMA
DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY OK 73117

SHIP TO:
STATE OF OKLAHOMA 1
DEPT OF HEALTH
1000 N.E. 10TH
ATTN SHIPPING & RECVG
OKLAHOMA CITY OK 73117
ATTN:LINDA WILSON/MCH

LINE NO.	CATALOG NUMBER	QUANTITY SHIPPED	UNIT	DESCRIPTION (LOT NO. / EXP. DATE / SERIAL NO.)	UNIT PRICE	AMOUNT	QUANTITY ORDERED	BACK ORDERED
001	05 556A	1	CS	KIMWIPE SML 4-1/2X8-1/2 280/PK VCAT: 34155	102.19	102.19	1	
				SHIPMENT TOTAL		102.19		

RECEIVED
NOV 17 1999
SHIPPING & RECEIVING

Linda Wilson

CUSTOMER ORDER NUMBER	ORDER NUMBER
T038610	*H93197123001*

PPA	NO. P/L	DATE ORDERED	NO. OF CTNS.		
11867		[illegible]		11/15/99	SEE REVERSE SIDE FOR FIELD DESCRIPTIONS

104253 10001115

LINDA @ 4470 PACKING LIST

SHIPMENT DETAIL DOCUMENT FORM 110T Rev. 1/97

** AGENCY COPY ** SVC CHF: NW

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T002321	105051

FOR AGENCY USE
WARRANT # 7149552 DATE: 08/18/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3113	000000000	11.85

CLAIM OF:
METROCALL
541215634

1 0 5 0 5 1

FOR
$ 11.85

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
025		11.85

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000728

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
06/24/2000	9123221	11.85

THIS SPACE FOR AGENCY USE

400BT00 000035NW0A 311310637Y 11.85

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

08/16/2000

Title Date

Agency, Bd or Div. Use

Ref claims: 105050 + 105049

METROCALL
AMERICA'S WIRELESS NETWORK

Split Funding

105050 pr

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 9123221
Invoice Date: 06/24/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
74.04	0.00	0.00	74.04	75.05	149.09

Payments received after 06/24/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance $ 74.04
Payments Received Through 06/24/00
Adjustments to Previous Balance
Total Balance Forward **Pay This Amount Now** $ 74.04

T002321
K022577

PURCHASE DOCUMENT	ACCOUNT NO.
COMPLETE PARTIAL	FUND NO.
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
INVOICE APPROVED	DATE 7-18-00

Current Charges 75.05
Service Charges
Usage Charges
Equipment & Accessories
Loss Protection
Account Adjustments
Connect Fee
Late Fee
Taxes & Other Charges

Total Current Charges **Pay Total Amount by 07/18/00 to Avoid Late Fee** $ 75.05 PAY

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
75.05	74.04	0.00	0.00	149.09

RECEIVED
JUL 1 2 2000
Personal Health Finance

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	9123221	06/24/00	75.05	~~149.09~~	75.05

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AV 01 001380 17843E 27 A**5DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000014909000007505912322128000700 8

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 9123221
Invoice Date: 06/24/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
74.04	0.00	0.00	74.04	75.05	149.09

Payments received after 06/24/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 74.04
Payments Received	
Total Balance Forward	**$ 74.04**

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 559-0435	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 620-9425	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 620-9604	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 620-9973	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 629-2533	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 630-3444	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 636-8629	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 647-2312	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 660-6396	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 9123221
Invoice Date: 06/24/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
74.04	0.00	0.00	74.04	75.05	149.09

Payments received after 06/24/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 660-7923	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 690-1115	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 690-1117	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 690-4708	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 770-0873	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 770-1191	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 770-1192	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(405) 770-4678	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(918) 220-6504	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
(918) 220-6511	DD with Extended Coverage	06/29/00 Thru 07/28/00	$ 3.95
Total Current Activity			$ 75.05

T002321 000035NLOA
023
266KOXO
43000 3113 10637Y
23.70
8/03/00

T002321 010035NLOA
024
190KOXO
41000 3113 10637Y
39.50
8/03/00

T002321 000035NWOA
025
400BT00
42000 3113 10637Y
11.85
8/03/00

Clmt

** AGENCY COPY ** SVC CHG: NW

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T070408	038508

FOR AGENCY USE
WARRANT # 0029567 DATE: 06/22/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3911	32000000	271.60

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		271.60

OSF-AUDITED BY

CLAIM OF:
CORR DEPT IND REV FUND 280
736017987

P.O.Address

0
3
8
5
0
8

FOR
$ 271.60
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

OFFICAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
280	131

Receipt	CFDA	Amount
7413100		271.60

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000510

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
05/10/2000	0059547	271.60

400BT00 000035NW97 391108564X 271.60

J/E XREF:

VENDOR: CORR DEPT IND REV FUND 280
ADDRESS: OK CORR INDUST (OCI/OSI)
ADDRESS: 4545 N LINCOLN, STE 103
CITY/ST/ZIP: OKLAHOMA CITY OK 73105

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached, provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must approved by the architect or engineer in charge of the project. Receiving reports may be susubmitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Instition or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 06/19/2000

Title Date

Agency, Bd or Div. Use

038508 PR

Oklahoma Correctional Industries
4545 N. Lincoln Suite 103
Oklahoma City, OK 73105

Telephone: 405/521-6038
1-800-522-3565

15B

Invoice No.: 0059547
Sales Order No.: 1001369
Customer No.: 210059

Invoice / TERMS NET 30 DAYS

Bill To:

STATE DEPT OF HEALTH
1000 NE 10TH STREET
ATTN ACCTS PAYABLE
OKLAHOMA CITY OK 73117-1299
Phone: 405/271-4042

Ship To:

OTTAWA COUNTY HEALTH DEPT.
ATTN:SUSAN WALDRON
1930 N. ELM STREET
MIAMI,OKLAHOMA 74354

Date	Shipping	Proj. Delivery	Terms
05/10/2000		/ /	

P.O.No.	Order Date	Salesman	Factory
T070408	03/30/2000	01 Dean Harback	021 M.A. SIGN SHOP

QTY.REQ	SHIPPED	ITEM No.	DESCRIPTION	PRICE	EXT.PRICE
4	4	SD3401	DECAL MAGNETIC SHEETING	60.400	241.60
			SIZE: 2" X 3" BACKGROUND COLOR:WHITE 1-SIDED LOGO 2-COLOR DIE CUT (NOT NESSASARY JUST CUT IN A RECTANGULAR SHAPE ARTWORK TO BE PROVIDED BY OSDH SENT TO SIGN SHOP BY DEAN H.		
3	3	SD39999	SET UP CHARGE FOR DECAL	10.000	30.00
			COLOR SPEC'D: PMS 116 FOR YELLOW SEP. PMS RED 032 FOR RED SEP. PMS 375 FOR NEON GREEN SEP.		

0-182
T070408 000035HW97
001 400BT00
F
PR 42000 391108564X
$271.60
6-8-00
PP SJT 6/14/00

POC: LINDA WILSON
PH:#271-4470

SALES CLERK:CHARITY

(Continued)

260-131 9413100

Oklahoma Correctional Industries
4545 N. Lincoln Suite 103
Oklahoma City, OK 73105

Telephone: 405/521-6038
1-800-522-3565

15B

Invoice No.: 0059547
Sales Order No.: 1001369
Customer No.: 210059

Invoice / TERMS NET 30 DAYS

RECEIVED 2000 MAY 12 A 10:38 GENERAL COUNSEL

Bill To:	Ship To:
STATE DEPT OF HEALTH 1000 NE 10TH STREET ATTN ACCTS PAYABLE OKLAHOMA CITY OK 73117-1299 Phone: 405/271-4042	OTTAWA COUNTY HEALTH DEPT. ATTN:SUSAN WALDRON 1930 N. ELM STREET MIAMI,OKLAHOMA 74354

Date	Shipping	Proj. Delivery	Terms
05/10/2000		/ /	

P.O.No.	Order Date	Salesman	Factory
T070408	03/30/2000	01 Dean Harback	021 M.A. SIGN SHOP

QTY.REQ	SHIPPED	ITEM No.	DESCRIPTION	PRICE	EXT.PRICE

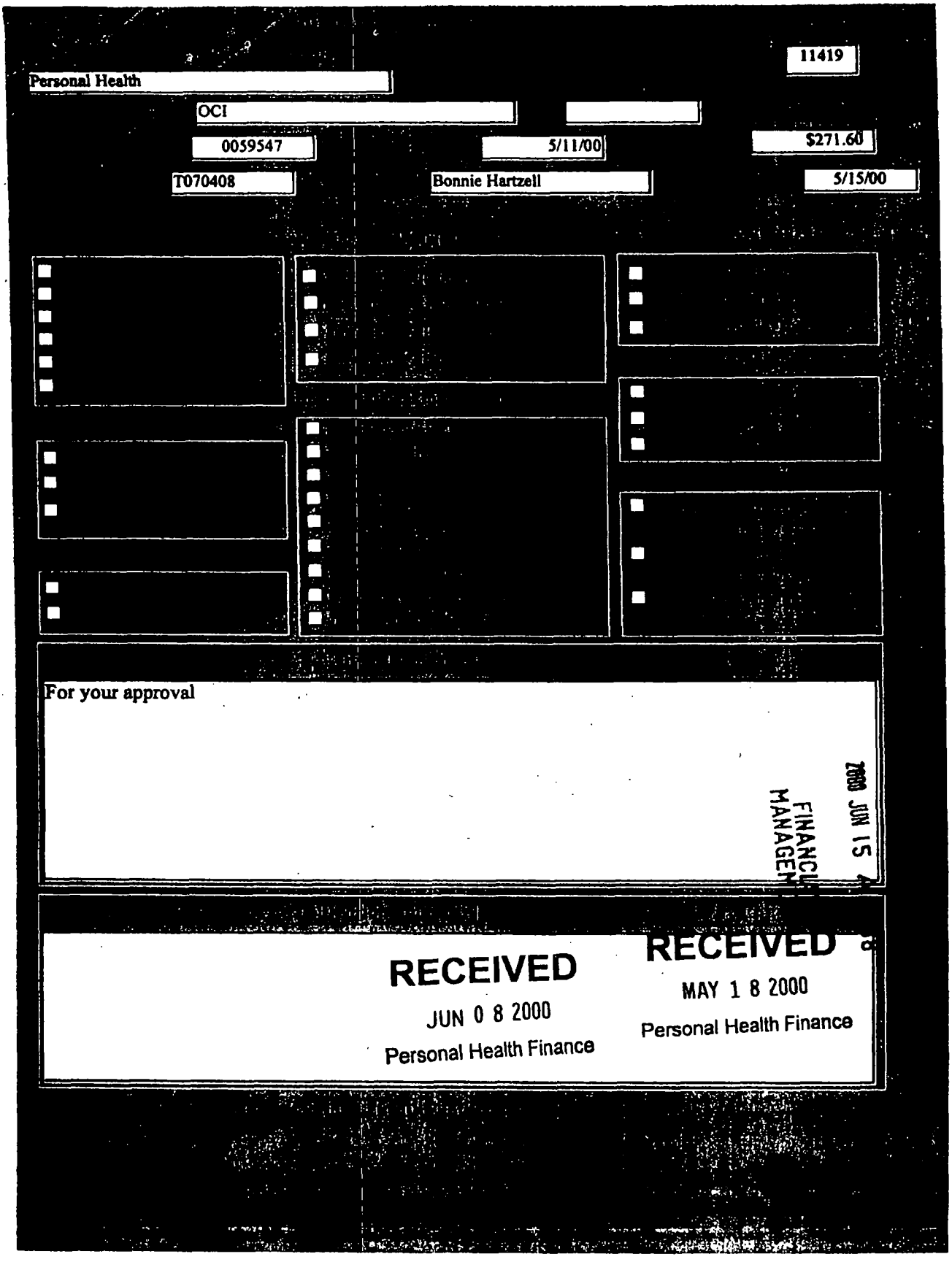
PH:#425-7504

RECEIVED 2000 MAY 15 P 1:58 GENERAL COUNSEL

PAYABLE TO CORR DEPT IND REV FUND 280
AGENCY 131 RECEIPT CODE 74131

Page No.: 2

Total:	271.60
Paid:	0.00
Balance:	271.60


11419
Personal Health
OCI
0059547
5/11/00
$271.60
T070408
Bonnie Hartzell
5/15/00
For your approval
2000 JUN 15
FINANCIAL MANAGEM
RECEIVED
JUN 0 8 2000
Personal Health Finance
RECEIVED
MAY 1 8 2000
Personal Health Finance

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T080623	038457

FOR AGENCY USE WARRANT # 8197751 DATE: 06/23/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3721	000000000	312.00

CLAIM OF:
ESA, INC
042447948

0 3 8 4 5 7

FOR
$ 312.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	312.00
001		OSF-AUDITED BY	

Receipt of Goods or Services Date (OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000526

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/22/2000	569014	312.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3721AAAAAX 312.00

J/E XREF:

VENDOR: ESA, INC
ADDRESS: 22 ALPHA RD
ADDRESS:
CITY/ST/ZIP: CHELMSFORD MA 018244171

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

06/19/2000
Date

Agency, Bd or Div. Use

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

	Date	Number
INVOICE	05/22/00	569014
Sales Order	05/22/00	216398

Ship Via UPS
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
1930 N. ELM STREET
ATTN: SUSAN WALDRON
HEALTH DEPT.
MIAMI, OK 74354

MAIL ORDER CF

Payment Terms NET 30 | Sales Rep # 36 | Cust PO T080623

Line	Qty	Part Number	Description	Unit Price	Value
1	8	70-3662	CAPILLARIES BLOOD LEAD COLLECTION	30.0000	240.00
2	8	70-3663	PLUNGERS BLOOD LEAD COLLECTION	9.0000	72.00

042447948 MIT
400BT00
000035NW97
42000
3721A-Y

001

RECEIVED

Sale Amount	312.00
Misc Amount	.00
Sales Tax	.00
Freight per PO	7.00
TOTAL	319.00

3120

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Sales Order - PICK LIST
Order

Date	Number
05/22/00	216398
05/22/00	

Ship Via UPS
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
1930 N. ELM STREET
ATTN: SUSAN WALDRON
HEALTH DEPT.
MIAMI, OK 74354

EL ORDER CF

yment Terms	Sales Rep # 36	Cust PO
T 30		T080623

no	Qty.	U/M	Part Number	Description	Scheduled Ship Date	Qty. Shipped
1	8	EA	70-3662	CAPILLARIES BLOOD LEAD COLLECTION 04699	05/22/00	8
			STOCKROOM: MAIN	LOCATION: BULK10		
2	8	EA	70-3663			8
			STOCKROOM: MAIN	LOCATION: BULK10		

Received
5/26/00

RECEIVED
JUN 0 2 2000
Personal Health Finance

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T038613	017630

FOR AGENCY USE
WARRANT # 7558335 DATE: 12/16/1999

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3721	932000000	117.04

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	115.87
001		OSF-AUDITED BY	

CLAIM OF:
SOUTH CENTRAL INDUSTRIES, INC
731138726

0
1
7
6
3
0

FOR
$ 115.87

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/10/1999	1101	115.87

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3721AAAAAX 117.04

J/E XREF:

VENDOR: SOUTH CENTRAL INDUSTRIES, INC
ADDRESS: 130 N. LOUISE
ADDRESS:
CITY/ST/ZIP: SHAWNEE OK 748023766

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

_____
Agency's Approving Officer

12/10/1999

017630 pl

SOUTH CENTRAL INDUSTRIES, INC.
P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer's Order No. T038613 Phone No. _____ Date 11-10-99

Name Okla State Dept of Health Attn: Accounts Payable

Address 1000 N.E. 10th Street OKC, Okla 73117

SOLD BY	CASH	C. O. D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT	

Quantity	DESCRIPTION	PRICE	AMOUNT	
1cs	0475-41-44-180	58.52	58	52
	Latex powderfree small			
1cs	0475-41-44-150	58.52	58	52
	Latex powderfree medium			
	100/box 10 boxes/case			
	Thank you!			
		TAX		
		TOTAL	117	04

CODE 15814

L

SE002816

ALL claims and returned goods MUST be accompanied by this bill.

Rec'd by _____

1101

Thank You

PRINTED IN U.S.A.

RECEIVED
NOV 10 1999
SHIPPING & RECEIVING

SHIPPED 11/10/99

CORP EXPRESS
1302957

1

SOUTH CENTRAL INDUSTRIES, INC.
P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer's Order No. T038613 Phone No. _____ Date 11-10-99

Name Okla State Dept of Health Attn: Accounts Payable

Address 1000 N.E. 10th Street OKC. Okla 73117

SOLD BY	CASH	C. O. D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT	

Quantity	DESCRIPTION	PRICE	AMOUNT	
1cs	0475-41-44-180	58.52	58	52
	Latex powder free small			
1cs	0475-41-44-150	58.52	58	52
	Latex powder free medium			
	100/box 10 boxes/case			
	Thank You!			
		TAX		
		TOTAL	117	04

400BT00
000035NW97
42000
3721 A-X

CODE 15814

ALL claims and returned goods MUST be accompanied by this bill.

Rec'd by _____ Thank You

1101

PRINTED IN U.S.A.

SHIPPED 11/10/99

CORP EXPRESS
1302957

RECEIVED
NOV 10 1999
SHIPPING & RECEIVING

TNDA 4470

12-3-99

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	113697

FOR AGENCY USE
WARRANT # 7437210 DATE: 11/08/2000

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000035	42000	3312	932000000	348.00
000135	42000	3312	932000000	348.00

FOR
$ 696.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARREN (LOCATOI NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
003		696.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000901

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/16/2000	404412	696.00

THIS SPACE FOR AGENCY USE

400BT00 000035NW97 3312AAAAAX 348.00
400BT01 000135NW97 3312AAAAAX 348.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 11/06/2000

Title Date

Agency, Bd or Div. Use

113697

The RKBlack Connection

RKBlack Inc. COPYSOLUTIONS Marathon

4111 PERIMETER CENTER PLACE · OKLAHOMA CITY, OKLA. 73112-9984
(405) 943-9801

PROCUREMENT
OCT 2 4 2000
RECEIVED

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

[redacted]

SHIP VIA:

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 73117-1[illegible]

ACCOUNT #: 2716868 [redacted]

ORD.	SHIP	TAX						
1	1	FA		* MAINTENANCE CONTRACT NO. 18330 BILLING PERIOD FROM 5/2/00 THROUGH 9/1/00 AFICIO COLOR 3006 RICOH EPG SERIAL NO. 0100100116 COPY USAGE FROM 5/2/00 THROUGH 9/1/00 CURRENT METER READING 16377 PRIOR METER READING 1 TOTAL COPIES 16376 COPIES INCL. IN USE CHARGE 30000 NET BILLABLE COPIES 0 SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013 DOES NOT INCLUDE SUPPLIES. RCV THIS BILLING REFLECTS THE INITIAL 4 MONTH BILLING.	4 months 174.00		174.00	696.00 ~~174.00~~
						SUBTOTAL		696.00 ~~174.00~~
						FREIGHT		.00
						SALES TAX		.00

RECEIVED
2000 OCT 24 PM 4:06
FINANCIAL MANAGEMENT

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

OVER

Please show INVOICE and ACCOUNT # on remittance [redacted]

The RKBlack Connection

RK Black Inc. COPYSOLUTIONS Marathon

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

PROCUREMENT

OCT 2 4 2000

RECEIVED

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

[redacted]

SHIP VIA:

SOLD TO

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 73117-1[illegible]

ACCOUNT # 2716868 [redacted]

ORD.	SHIP	B.O.	U/M					
1	1	RECEIVED 2000 OCT 24 PM 4:06	EA	* MAINTENANCE CONTRACT NO. 18330 BILLING PERIOD FROM 5/2/00 THROUGH 9/1/00 4 months AFICIO COLOR 3006 RICOH EPG SERIAL NO. 0100100116 COPY USAGE FROM 5/2/00 THROUGH 9/1/00 CURRENT METER READING 16377 PRIOR METER READING 1 TOTAL COPIES 16376 COPIES INCL. IN USE CHARGE 30000 NET BILLABLE COPIES 0 SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013 DOES NOT INCLUDE SUPPLIES. RCV THIS BILLING REFLECTS THE INITIAL 4 MONTH BILLING.	174.00		174.00	696.00 ~~174.00~~
							SUBTOTAL	696.00 ~~174.00~~
							FREIGHT	.00
							SALES TAX	.00

FINANCIAL MANAGEMENT

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

OVER

Please show INVOICE and ACCOUNT # on remittance [redacted]

The RKBlack Connection

RK Black Inc. COPYSOLUTIONS Macintosh

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-6984
(405) 943-9801

PROCUREMENT
OCT 2 4 2000
RECEIVED

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

[redacted]

SHIP VIA:

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 73117-1[illegible]

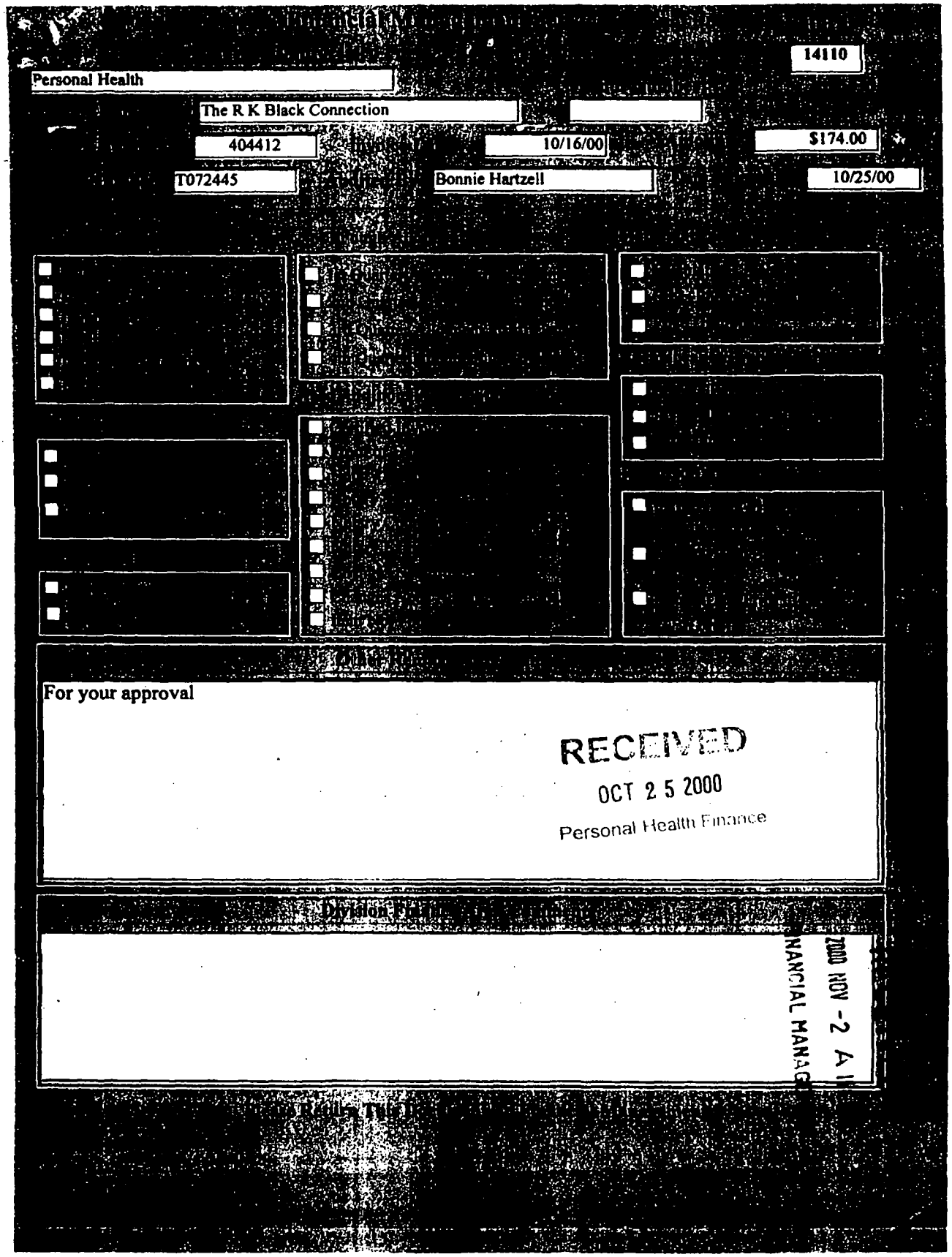
ACCOUNT # 2715860 [redacted]

ORD.	SHIP	TAX	DATE				
1	1	RECEIVED 2000 OCT 24 PM 4:06 FINANCIAL MANAGEMENT	PA	* MAINTENANCE CONTRACT NO. 18330			696.00
				BILLING PERIOD FROM 5/2/00 THROUGH 9/1/00	4 months		
				AFICIO COLOR 3006 RICOH EPG	174.00	174.00	~~174.00~~
				SERIAL NO. 0100100116 ✓ ✓			
				COPY USAGE FROM 5/2/00 THROUGH 9/1/00			
				CURRENT METER READING 16377			
				PRIOR METER READING 1			
				TOTAL COPIES 16376			
				COPIES INCL. IN USE CHARGE 30000			
				NET BILLABLE COPIES 0			
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013			
				DOES NOT INCLUDE SUPPLIES. RCV			
				THIS BILLING REFLECTS THE INITIAL 4 MONTH BILLING.			696.00
						SUBTOTAL	~~174.00~~
						FREIGHT	.00
						SALES TAX	.00
						[redacted]	

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

OVER

Please show INVOICE and ACCOUNT # on remittance


14110
Personal Health
The R K Black Connection
404412
10/16/00
$174.00
T072445
Bonnie Hartzell
10/25/00
For your approval
RECEIVED
OCT 2 5 2000
Personal Health Finance
2000 NOV -2 A
NANCIAL MANAG

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X029635	112202

FOR AGENCY USE WARRANT # 7390884 DATE: 10/25/2000

CLAIM OF:
ENVIRONMENTAL EXPRESS
570890924

1 1 2 2 0 2

FOR
$ 156.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	932000000	150.00
000135	42000	3111	932000000	6.00

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	156.00
001		OSF AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001006

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/03/2000	1000018418	156.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3614AAAAAX 150.00
400BT01 000135NW97 3111AAAAAX 6.00

J/E XREF:

VENDOR: ENVIRONMENTAL EXPRESS
ADDRESS: PO BOX 669
ADDRESS:
CITY/ST/ZIP: MOUNT PLEASANT SC 29465

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 10/23/2000

Title Date

Agency, Bd or Div. Use

112202 pr

ENVIRONMENTAL EXPRESS LTD
490 WANDO PARK BLVD
PO BOX 669
MT PLEASANT, SC 29464
Telephone: 843-881-6560
Warehouse: MAIN

INVOICE

Invoice No.	[redacted]
Customer No.	SOKDOH

Bill To:
STATE OF OKLAHOMA DEPT OF HEALTH
A/P
1000 NE 10TH ST
OKLAHOMA CITY, OK 73117-1299
US
Telephone: 405-271-4470

Ship To:
STATE OF OKLAHOMA DEPT OF HEALTH
SHIPPING AND RECEIVING
1000 NE 10TH ST
OKLAHOMA CITY, OK 73117
US

Ship Via	F.O.B.	Terms	Salesperson
UPS GROUND	Point of Origin	NET 30	

Ship Date	Order Date	SO #	Ordered By	PO #	Resale #
[redacted]	10/03/00	10016436	MAIL MARY FIELDS	[redacted]039635	

UM SO Quantity	Shipped Quantity	Tax	Item Number / Item Description	Unit Price	Extended Price
1.00	1.00	Y	SC4250 U of M: Pack Ghost Wipe in individual sealed packs 1000/pk	150.00	150.00

SF0890924

X029635 PURCHASE DOCUMENT
000135 NW97 ACCOUNT NO.
1001 COMPLETE [ ] PARTIAL
400 BTOL FUND NO.
42050 MATH CHECKED
[ ] OBJECT CODE
[ ] CLAIM ENTERED
[ ] CLAIM NUMBER
Pleam 10-23-00 INVOICE APPROVED DATE

3614A-X = 150
3111A-X1 = 6

FINANCIAL MANAGEMENT
2000 OCT 12 AM 11:16
RECEIVED

Print Date / Page	10/04/00 09:17:17 AM 1

Total Paid	0.00
Balance Due	156.00

Amount due is based on 'Terms' above.

Subtotal	150.00
Freight	6.00
Invoice Total	156.00

10-19-00

PACKING SLIP

ENVIRONMENTAL EXPRESS LTD
490 WANDO PARK BLVD
PO BOX 669
MT PLEASANT, SC 29464
PO BOX ZIP 29465
Telephone: 843-881-6560
Warehouse: MAIN

[redacted]	1000018418
	SOKDOH

Bill To:

STATE OF OKLAHOMA DEPT OF HEALTH
A/P
1000 NE 10TH ST
OKLAHOMA CITY, OK 73117-1299
US
Telephone : 405-271-4470

Ship To:

STATE OF OKLAHOMA DEPT OF HEALTH
SHIPPING AND RECEIVING
1000 NE 10TH ST
OKLAHOMA CITY, OK 73117
US

Ship Via	F.O.B.	Terms	
UPS GROUND	Point of Origin	NET 30	

Ship Date	Order Date	[illegible]	[illegible]	[illegible]	
10/03/00	10/03/00	10016436	MAIL MARY FIELDS	X029635	

Order Quantity	Back Order Quantity	Quantity Shipped		
1.00	0.00	1.00	SC4250 Ghost Wipe in individual sealed packs 1000/pk	U of M: Pack

RECEIVED
OCT 0[illegible]2000
SHIPPING & RECEIVING

Print Date	10/03/00
Print Time	04:37:25 PM
Page #	1

Linda Wilson

Prepared By: Dick Casner

[illegible]

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	111668

FOR AGENCY USE WARRANT # 7380864 DATE: 10/23/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932000000	2.24

CLAIM OF:
METROCALL
541215634

FOR
$ 10.14

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
018		10.14

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001028

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
09/23/2000	1359667	10.14

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 311310637Y 7.90
400BX01 000135NH0A 311310637Y 2.24

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 10/19/2000

Title Date

Agency, Bd or Div. Use

111668 pe

Ref claims 111666 + 111667

METROCALL				
ACCOUNT NUMBER 505-022564-28				
PURCHASE ORDER NUMBER	X002279			
INVOICE DATE	9/23/00			
INVOICE NUMBER	1359667			
FUND\ACCOUNT\SUBACT	**OEC**	**AMOUNT**	**LIQ NUM.**	
191KDX1_010135NE0A_41000	3113 10637Y	31.60	016	
266KDX1_000135NL0A_43000	3113 10637Y	19.75	017	
400AT11_000135TN0A_42000	3113 10637Y	0.00		
400B811_000135NE0A_41000	3113 10637Y	0.00		
400BT01_000135NW97_42000	3113 10637Y	7.90	018	
400BX01_000135NH0A_42000	3113 10637Y	2.24	018	
400CX11_000135NN0A_42000	3113 10637Y	0.00		
	TOTAL	61.49		
funded by Sonja F. [illegible]				
date 10/11/00				

Ref Cl's

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 1359667
Invoice Date: 09/23/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
143.69	0.00	0.00	143.69	65.44	209.13

Payments received after 09/23/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance $ 143.69
Payments Received Through 09/23/00
Adjustments to Previous Balance
Total Balance Forward **Pay This Amount Now** $ 143.69

Current Charges
Service Charges
Usage Charges
Equipment & Accessories
Loss Protection
Account Adjustments
Connect Fee
Late Fee
Taxes & Other Charges
Total Current Charges $ 65.44

X0022579
PURCHASE DOCUMENT | ACCOUNT NO.
COMPLETE | PARTIAL | FUND NO.
MATH CHECKED | OBJECT CODE
CLAIM ENTERED | CLAIM NUMBER
PP 10-6-00
INVOICE APPROVED | DATE

RECEIVED
OCT 06 2000
Personal Health Finance 61.49

Pay Total Amount by 10/17/00 to Avoid Late Fee ~~$ 65.44~~

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
65.44	70.70	72.99	0.00	209.13

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	1359667	09/23/00	65.44	209.13	

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AV 02 001147 20827E 24 A**5DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000020913000006544135966728001O007

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 1359667
Invoice Date: 09/23/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
143.69	0.00	0.00	143.69	65.44	209.13

Payments received after 09/23/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance Payments Received	$ 143.69
Total Balance Forward	$ 143.69

Current Activity

Pager Number	Service Description	Service Dates	Amount	
(405) 505-0234	DD		$ 0.00	
Higgins, K. (405) 559-0435	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	CF
Gehue, C. (405) 620-9425	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP
[illegible] (405) 620-9604	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP
Talley, J. (405) 620-9973	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP
Rollins, D. (405) 630-3444	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP
Clark, [illegible] (405) 636-8629	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP
[illegible] (405) 647-2312	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP
Jones, [illegible] (405) 660-6396	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	CP
Mar[illegible] (405) 660-7923	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 1359667
Invoice Date: 09/23/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
143.69	0.00	0.00	143.69	65.44	209.13

Payments received after 09/23/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount	
Ramsey, M. (405) 690-1115	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	CF
Ales, B. (405) 690-1117	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	CF
Fudge, W. (405) 690-4708	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OCAP
Bonner, J. (405) 770-0873	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	CF
(405) 770-1191	DD	09/15/00 Thru 09/28/00	$ 1.71 CR	
Middleton, K. (405) 770-1192	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	SSDI
(405) 770-4678	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ ~~3.95~~	
Horton, N. (918) 220-6504	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OBL
Waldron, S. (918) 220-6511	DD with Extended Coverage	09/29/00 Thru 10/28/00	$ 3.95	OBL
Total Current Activity			**$ 65.44**	

CF = 19.75
OCAP = 31.60
SSDI 2.24
OBL 7.90
61.49

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** /SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	113129

FOR AGENCY USE
WARRANT # 7418380 DATE: 11/02/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932000000	3.95

CLAIM OF:
METROCALL
541215634

1 1 3 1 2 9

FOR
$ 11.85

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
006		11.85

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20000828

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
07/22/2000	9881194	11.85

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 311310637Y 7.90
400BX01 000135NH0A 311310637Y 3.95

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 10/31/2000

Title Date

Agency, Bd or Div. Use

113129 MT

split fund

METROCALL
STATE-DOH\CHILD ABUSE
ACCOUNT NUMBER 505-022554-28

541 21 56 34 MT

PURCHASE ORDER NUMBER	X002279
INVOICE DATE	7/22/00
INVOICE NUMBER	9881194

FUND\ACCOUNT\SUBACT	OEC	AMOUNT	LIQ NUM.
191KDX1_010135NE0A_41000	3113 10637Y	35.55	004
266KDX1_000135ML0A_43000	3113 10637Y	27.65	005
400AT11_000135TN0A_42000	3113 10637Y	0.00	
400B811_000135NE0A_41000	3113 10637Y	0.00	
400BT01_000135NW97_42000	3113 10637Y	7.90	006
400BX01_000135NH0A_42000	3113 10637Y	3.95	006
400CX11_000135NN0A_42000	3113 10637Y	0.00	
	TOTAL	75.05	

funded by
date 10/4/00

RECEIVED
2000 OCT 17 P 4:31
FINANCIAL MANAGEMENT

ok

Ref # 113127
113128

RECEIVED
OCT 11 2000
Personal Health Finance

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 9881194
Invoice Date: 07/22/00
P. O. Number: ~~T002321~~

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
149.09	76.10	0.00	72.99	75.05	148.04

Payments received after 07/22/00 will be reflected on your next invoice.

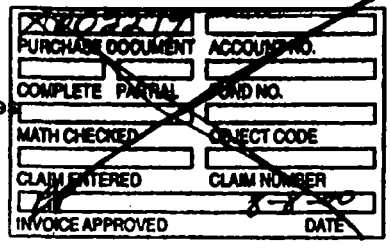
Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance	$	149.09
Payments Received Through 07/22/00	$	76.10
Adjustments to Previous Balance		
Total Balance Forward		

Pay This Amount Now $ 72.99

Current Charges	
Service Charges	$ 75.05
Usage Charges	
Equipment & Accessories	
Loss Protection	
Account Adjustments	
Connect Fee	
Late Fee	
Taxes & Other Charges	
Total Current Charges	



RECEIVED
OCT 1 1 2000
Personal Health Finance

Pay Total Amount by 08/15/00 to Avoid Late Fee $ 75.05

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
75.05	72.99	0.00	0.00	148.04

RECEIVED
AUG 0 9 2000
Personal Health Finance

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 9881194
Invoice Date: 07/22/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
149.09	76.10	0.00	72.99	75.05	148.04

Payments received after 07/22/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 149.09
Payments Received	$ 76.10
Total Balance Forward	**$ 72.99**

Current Activity

Pager Number	Service Description	Service Dates	Amount	
EXTRA (405) 559-0435	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	266
Gehue, C. (405) 620-9425	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Robertson, L. (405) 620-9604	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Talley, J. (405) 620-9973	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Ramrow, P. (405) 629-2533	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Rollins J. (405) 630-3444	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Clark, G. (405) 636-8629	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Carter, S. (405) 647-2312	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Jacobi, A. (405) 660-6396	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	266

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 9881194
Invoice Date: 07/22/00
P. O. Number: T002321

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

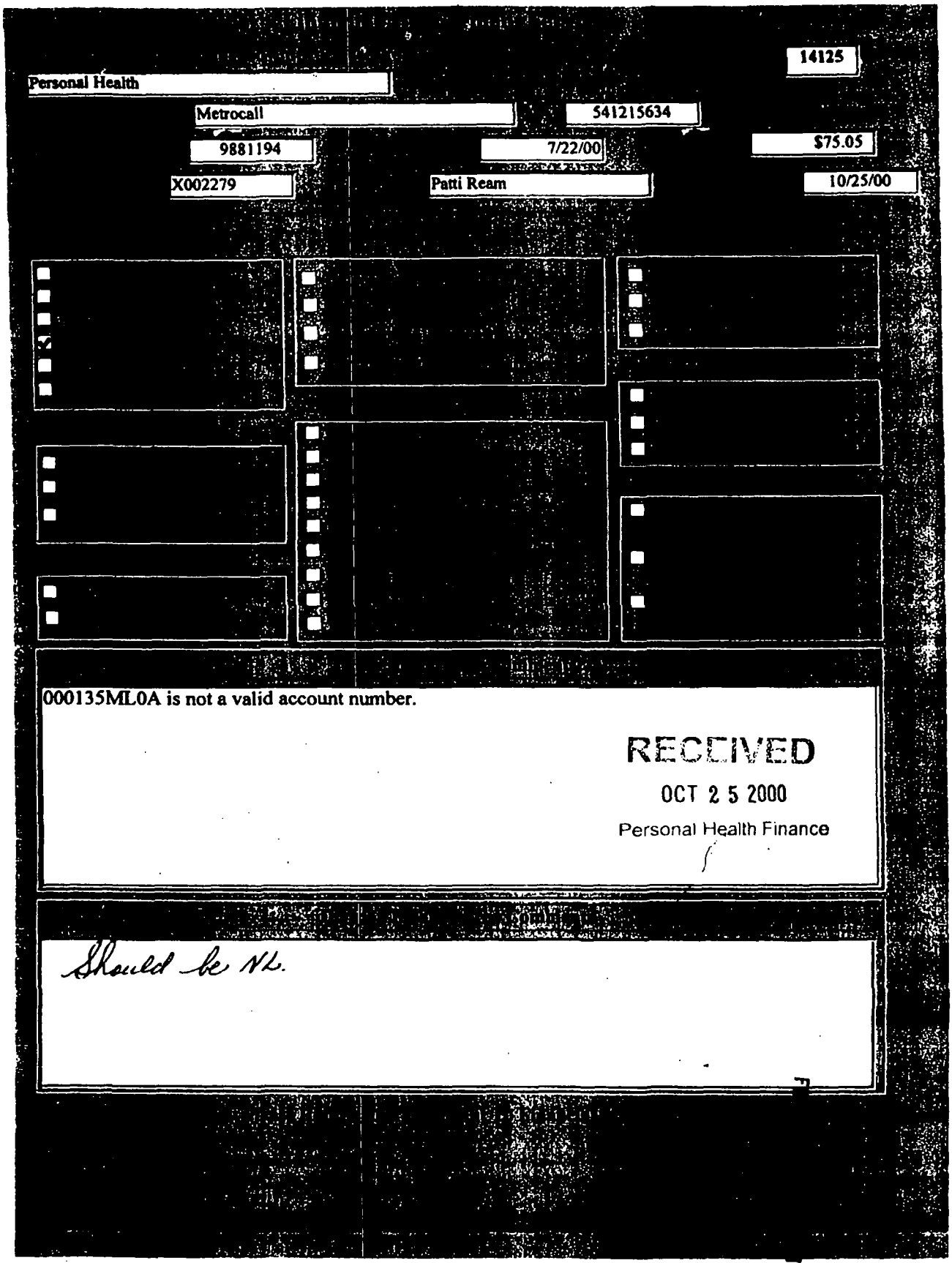
Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
149.09	76.10	0.00	72.99	75.05	148.04

Payments received after 07/22/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount	
Marr, P. (405) 660-7923	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Ramsey M. (405) 690-1118	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	266
Ales, B. (405) 690-1117	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	266
Fudge, D. (405) 690-4708	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	191
Bonner, J. (405) 770-0873	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	266
Hardesty, E. (405) 770-1191	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	266
Middleton R. (405) 770-1192	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	400-NW
Gunn, S. (405) 770-4678	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	266
Horton, N. (918) 220-6504	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	400-NW
Waldron, S. (918) 220-6511	DD with Extended Coverage	07/29/00 Thru 08/28/00	$ 3.95	400-NW
Total Current Activity			$ 75.05	


14125
Personal Health
Metrocall
541215634
9881194
7/22/00
$75.05
X002279
Patti Ream
10/25/00
000135ML0A is not a valid account number.
RECEIVED
OCT 2 5 2000
Personal Health Finance
Should be NL.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	114153

FOR AGENCY USE
WARRANT # 7448937 DATE: 11/13/2000

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1 1 4 1 5 3

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	105570002	174.00

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		174.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001002

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
09/26/2000	401536	174.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3312AAAAAX 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/08/2000

Title Date

Agency, Bd or Div. Use

The Black Connection

Black Inc. COPYSOLUTIONS Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

RECEIVED

OCT 0 4 2000

Personal Health Finance

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
401536	NET 10

RECEIVED

OCT 1 2 2000

Personal Health Financ

T072445 000135NW97

PURCHASE DOCUMENT 001 ACCOUNT NO. 400BT01

COMPLETE PARTIAL 42000 FUND NO. 3372D-X

MATH CHECKED OBJECT CODE

CLAIM ENTERED CLAIM NUMBER

PP 10-6-00 DATE

SHIP TO

SHIP VIA:

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

DEQ-OTTAWA
1930 NORTH ELM
MIAMI OK 73117

	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
6868	T072445	OK HOUSE ACCOUN		9/26/00	9/26/00

SHIP	S.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
					CANNOT PAY IN ADVANCE			
			* MAINTENANCE CONTRACT NO. 18330					
			BILLING PERIOD FROM 9/2/00 THROUGH ~~1/1/01~~ 10/02/00					174.00
4		EA	AFICIO COLOR 3006	RICOH EPG	174.00		174.00	~~696.~~
			SERIAL NO. 0100100116					
			COPY USAGE FROM 5/2/00 THROUGH 9/1/00					
			CURRENT METER READING 16377					
			PRIOR METER READING 1					
			TOTAL COPIES 16376					
			COPIES INCL. IN USE CHARGE 30000					
			NET BILLABLE COPIES 0					
			SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
			DOES NOT INCLUDE SUPPLIES. RCV					
			THIS BILLING FOR MONTH PERIOD. FUTURE BILLINGS					
			WILL BILL MONTHLY... RCV					174.00
					SUBTOTAL			~~696.~~

REMENT

3 2000

EIVED

FINANCIAL MANAGEMENT

2000 OCT -4 A 7:48

RECEIVED

MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

CONTINUED

KIM PERRY

Personal Health

13829

The R K Black Connection

401536

9/26/00

$696.00

T072445

Bonnie Hartzell

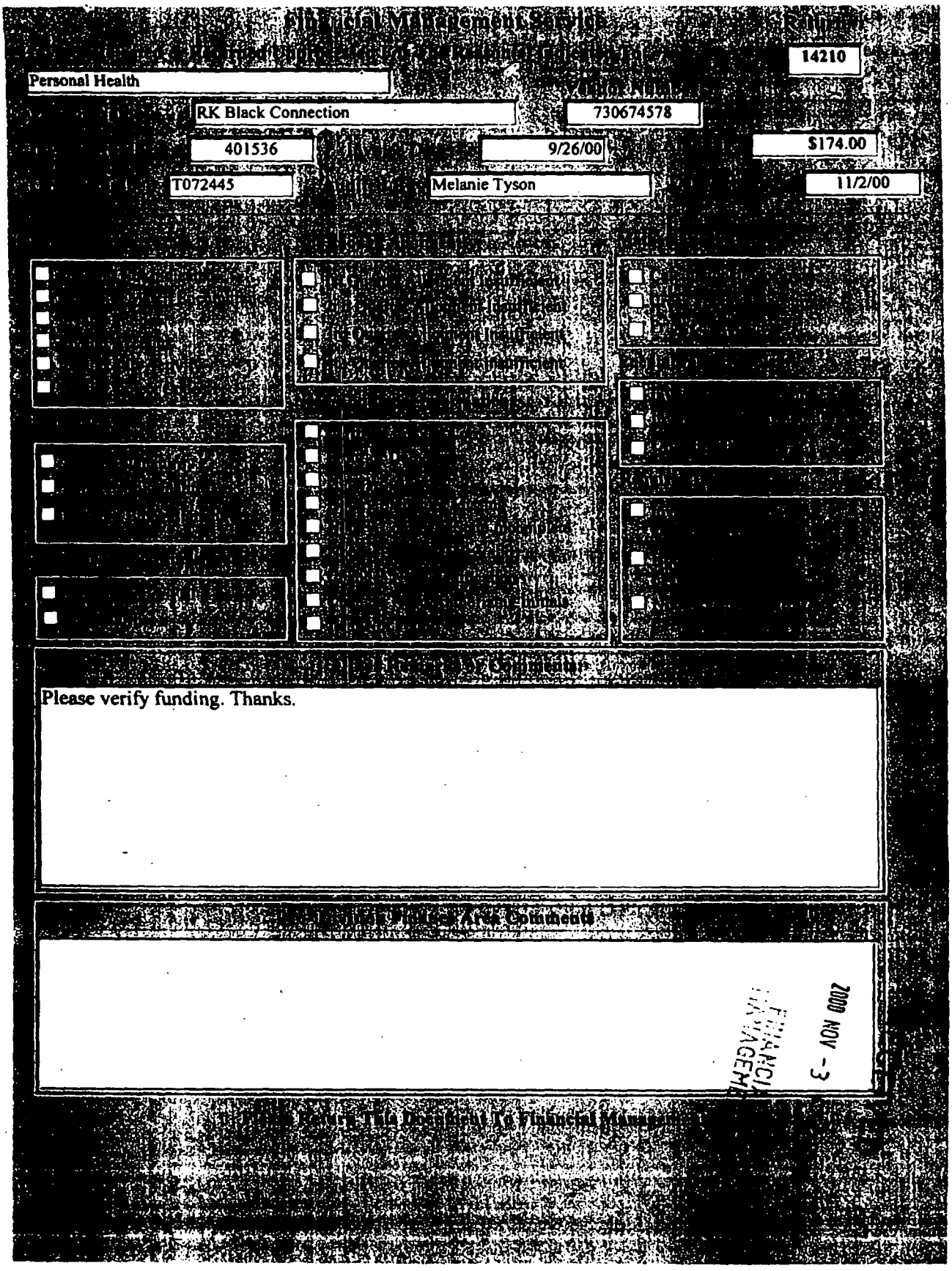
10/4/00

For your approval

RECEIVED
OCT 12 2000
Personal Health Finance

RECEIVED
OCT 04 2000
Personal Health Finance

ASSUMPTION - This replaces the IKON invoices


14210
Personal Health
RK Black Connection
730674578
401536
9/26/00
$174.00
T072445
Melanie Tyson
11/2/00
Please verify funding. Thanks.
2000 NOV -3

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X030526	115516

FOR AGENCY USE
WARRANT # 7500239 DATE: 11/29/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3426	000000000	4,985.00

CLAIM OF:
ESA, INC
042447948

1 1 5 5 1 6

FOR
$ 4,985.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001	YES	4,985.00

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001013

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/11/2000	571964	4,985.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3426AAAAAX 4985.00

J/E XREF:

VENDOR: ESA, INC
ADDRESS: 22 ALPHA RD
ADDRESS:
CITY/ST/ZIP: CHELMSFORD MA 018244171

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

11/22/2000
Date

Agency, Bd or Div. Use

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7099

	Date	Number
INVOICE	10/11/00	$71964
Sales Order	10/10/00	218993

Ship Via UPS
F.O.B. FACTORY
Ship Term
Bill of Lading

Bill To:
10565 *OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
*OKLAHOMA STATE DEPARTMENT OF
1930 N. ELM STREET
RECEIVING
ATTN: SUSAN WALDRON
MIAMI, OK 74354

MAIL ORDER OF

Payment Terms	Sales Rep #	Cust PO
NET 30	36	X030526

Line	Qty	Part Number	Description	Price	Value
1	15	70-3662	CAPILLARIES BLOOD LEAD COLLECTION	30.0000	450.00
2	15	70-3663	PLUNGERS BLOOD LEAD COLLECTION	9.0000	135.00
3	20	70-2233	LEADCARE BLOOD LEAD TEST KIT	220.0000	4400.00

04344748
X030526 000135NW97
001F 400BT01
42000 3126A-X

PReam 11-1-00

Sale Amount	4985.00
Misc Amount	.00
Sales Tax	.00
Freight	21.20
TOTAL	5006.20

Freight disallowed per P.O.
4985.00

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

Ream, Patti J.

From: Fouquet, Sonja F.
Sent: Wednesday, November 22, 2000 11:02 AM
To: Ream, Patti J.
Subject: FW: ESA Inc PO#x030526

One down and one to go. Please pay ESA P.O. X030526

----Original Message----
From: Perry, Pamela S.
Sent: Wednesday, November 22, 2000 10:52 AM
To: Fouquet, Sonja F.
Cc: Ream, Patti J.
Subject: RE: ESA Inc PO#x030526

All items have been received. Please pay. Vendor is calling about their money.

----Original Message----
From: Fouquet, Sonja F.
Sent: Thursday, November 16, 2000 9:55 AM
To: Perry, Pamela S.
Subject: FW: ESA Inc PO#x030526
Importance: High

I haven't gotten an answer to this one, I don't think. Fairly certain, we have received items, but need definite verification. Do they send packing slips to you , financial management , Ken, or do they get sent at all?

----Original Message----
From: Ream, Patti J.
Sent: Thursday, November 16, 2000 8:21 AM
To: Fouquet, Sonja F.
Subject: FW: ESA Inc PO#x030526
Importance: High

Did we receive these?
----Original Message----
From: Ream, Patti J.
Sent: Wednesday, November 01, 2000 12:54 PM
To: Fouquet, Sonja F.
Subject: ESA Inc PO#x030526

I have an invoice for items shipped to Ottowa County, but no signed delivery receipt. Can you confirm for me the following items were received:

15 item 70-3662 Capillaries Blood Lead Collection @ $30.00 ea	$ 450.00
15 item 70-3663 Plungers Blood Lead Collection @ $9.00 ea	$ 135.00
20 item 70-2233 Leadcare Blood Lead Test Kit @ $220.00 ea	$4400.00

Total invoice $4985.00. The invoice date is 10-11-00, so they would have been received around the same time.

Thanks - Patti Ream

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X029629	114682

FOR AGENCY USE
WARRANT # 7469060 DATE: 11/17/2000

CLAIM OF:
TAYLOE PAPER CO
730477150

1 1 4 6 8 2

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	841810000	146.00

FOR
$ 146.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant:

WARRENT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		146.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001014

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/12/2000	3012585-00	146.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3614AAAAAX 146.00

J/E XREF:

VENDOR: TAYLOE PAPER COMPANY
ADDRESS: DEPT NO 146
ADDRESS: PO BOX 21228
CITY/ST/ZIP: TULSA OK 741211228

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/15/2000

Title Date

Agency, Bd or Div. Use

114682-PR

TAYLOE

Document: Invoice

Salesman: 073

Invoice Date: 10/12/00

Order #: 3012585-00

Cust #: 600274

PO Date: 10/04/00

PO #: X029629

Page #: 1

Ship To: OTTAWA CO HEALTH DEPT
1930 N ELM
ATTN SUSAN WALDRON
MIAMI, OK 74354

Remit To: Tayloe Paper Company
Dept# 146
PO Box 21228
Tulsa, OK 74121-1228

Instructions: SHIP COMPLETE

Via: Tayloe Truck

Ship From: Tayloe Joplin Warehouse

Bill To: OKLA STATE HEALTH DEPT
1000 N E 10TH
P O BOX 53551
OKLA CITY, OK 73152

Shipped: 10/12/00

Terms: Net 30

Ln#	Product And Description	Quantity Ordered	Quantity B.O.	Quantity Shipped	Qty. UM	Unit Price	Price UM	Discount Multiplier	Amount (Net)
1	26942 8 1/2x11 10M 20 BLUE HAMM'L FORE DP	5000	0	5000	EA	5.84	M	0.00	29.20
2	26943 8 1/2X11 10M 20 LILAC HAMM'L FORE DP	5000	0	5000	EA	5.84	M	0.00	29.20
3	26946 8 1/2X11 10M 20 CANARY HAMM'L FORE DP	5000	0	5000	EA	5.84	M	0.00	29.20
4	26948 8 1/2X11 10M 20 GREEN HAMM'L FORE DP	10000	0	10000	EA	5.84	M	0.00	58.40

4 Lines Total Qty Shipped Total 25000 Total 146.00 Invoice Total 146.00

730477150

X029629 000136NW9 7

001 400BT01

42000 3614A-X

Pream 11-13-00

Last Page

Cash Discount 0.00 If Paid By 10/12/00

Ream, Patti J.

From: Perry, Pamela S.
Sent: Wednesday, November 15, 2000 8:58 AM
To: Fouquet, Sonja F.
Cc: Ream, Patti J.
Subject: RE: Tayloe PO X029629

This has been received so please pay.

-----Original Message-----
From: Fouquet, Sonja F.
Sent: Monday, November 13, 2000 10:16 AM
To: Perry, Pamela S.
Subject: FW: Tayloe PO X029629

This is Ottawa Blood Lead, delivered to the county. Do you have anything? Linda Wilson, agency contact was replaced by Romaine Murphy.

-----Original Message-----
From: **Ream, Patti J.**
Sent: Monday, November 13, 2000 10:00 AM
To: Fouquet, Sonja F.
Subject: Tayloe PO X029629

I have an invoice dated 10-12 from Tayloe for 5000 each of blue, lilac, canary and green paper. Did we receive? Funding is 35NW Thanks - Patti

Ream, Patti J.

From: Fouquet, Sonja F.
Sent: Wednesday, November 15, 2000 9:41 AM
To: Ream, Patti J.
Subject: FW: Tayloe PO X029629

This one is okay to pay

-----Original Message-----
From: **Perry, Pamela S.**
Sent: Wednesday, November 15, 2000 8:58 AM
To: Fouquet, Sonja F.
Cc: Ream, Patti J.
Subject: RE: Tayloe PO X029629

This has been received so please pay.

-----Original Message-----
From: Fouquet, Sonja F.
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To: Perry, Pamela S.
Subject: FW: Tayloe PO X029629

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Subject: Tayloe PO X029629

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** AGENCY COPY ** SVC CHF: NW

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X029948	115086

FOR AGENCY USE
WARRANT # 7478934 DATE: 11/21/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	000000000	189.80

CLAIM OF:
ARCHER OFFICE PRODUCTS
731132461

1150886

FOR
$ 189.80

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRENT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	189.80
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001003

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/03/2000	10056300	189.80

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3614AAAAAX 189.80

J/E XREF:

VENDOR: ARCHER OFFICE PRODUCTS
ADDRESS: 11515 S PORTLAND
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73170

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

11/17/2000
Date

Agency, Bd or Div. Use

ARCHER OFFICE PRODUCTS
WWW.ARCHER.PRIMEOP.COM
11515 S. PORTLAND
OKLAHOMA CITY OK 73170

Invoice 1005630-0

ORDER TAKER:4350

CUSTOMER # 439489 **DEPT 01** **RTE#9** **PAGE :** 1

1150810

Sold To STATE HEALTH DEPARTMENT
1000 NE 10
OKLAHOMA CITY OK 73117

CHARGE

Ship To OTTAWA COUNTY HEALTH DEPT
1930 NORTH ELM
ATTN SUSAN WALDRON
MIAMI OK 74354

CUSTOMER NUMBER	SLSMN ID	PO NUMBER		INVOICE DATE	CUSTOMER PHONE	
439489	4305	X029948		10/03/00	405-271-4043	

QTY ORDER	QTY SHIPPED	QTY B/O	LOC	ITEM NUMBER	DESCRIPTION	UNIT	PRICE PER UNIT	EXTENDED TOTAL
				Who Called : LINDA WILSON 271 4470				
20	20		SPAR	C6039A	HEW PAPER,PREMIUM PHOTO,15/S	BX	9.490	189.80

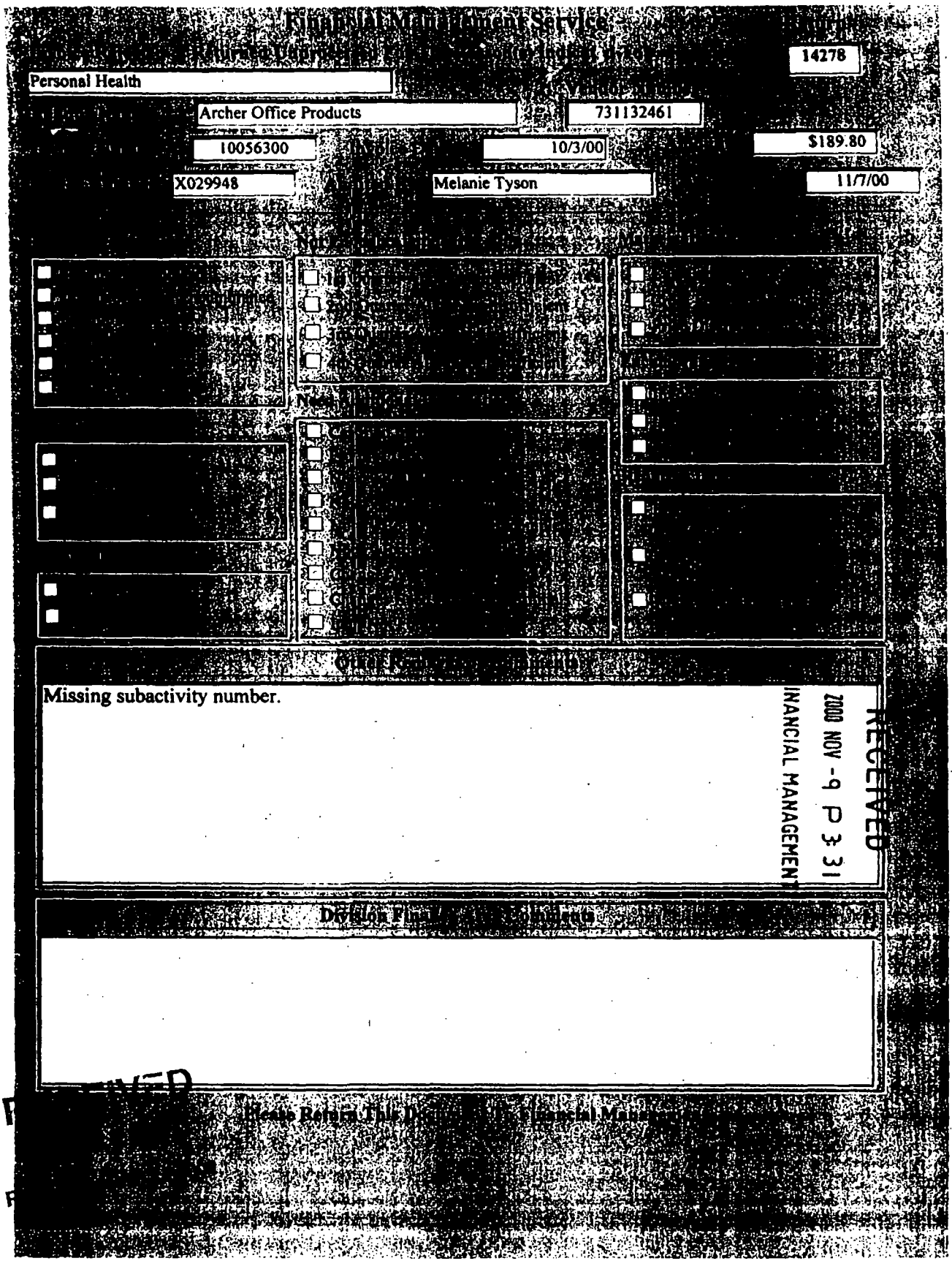
X029948 PURCHASE DOCUMENT
CCC135NW97 ACCOUNT NO.
OC1 COMPLETE PARTIAL
400BTC1 FUND NO.
3614 A-X
MATH CHECKED
OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
PP INVOICE APPROVED
10-24-00 DATE

Received 10/6/00
Susan Waldron

RECEIVED
OCT 25 2000
Personal Health Finance

Subtotal	189.80
Tax	.00
Total	189.80

Please Remit To:
Archer Office Products, Inc. Lockbox # 99038 Oklahoma City, OK 73199
To ensure proper credit, refer to your Customer Number and Invoice Number above.



Financial Management Service

14278

Personal Health

Archer Office Products

731132461

10056300

10/3/00

$189.80

X029948

Melanie Tyson

11/7/00

Missing subactivity number.

RECEIVED
2000 NOV -9 P 3:31
FINANCIAL MANAGEMENT

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X036124	115504

FOR AGENCY USE
WARRANT # 7510587 DATE: 12/01/2000

CLAIM OF:
IKON OFC SOLUTIONS
230334400

1 1 5 5 0 4

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	937770000	577.60

FOR $ 577.60

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	577.60
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001031

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/31/2000	72683A	577.60

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3614AAAAAX 577.60

J/E XREF:

VENDOR: IKON OFC SOL/DOC SVCS (#11501)
ADDRESS: DEPT. 96-0075
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73196-007

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

11/22/2000
Date

Agency, Bd or Div. Use

IKON Office Solutions

SHIP TO INVOICE Page # 1

IKON Customer Service Cente
Call Toll Free 1-877-783-4566

SHIPPED TO

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

INVOICE INFORMATION

Customer #	J7A526	Dist. Code	00
Date	10/31/00	Order Date	10/31/00
Invoice #	72683A	Ship Date	10/31/00
PO Number	X036124	Shipped VIA	UPS GROUND

BILLING INFORMATION

115504 pk

**********AUTO**MIXED AADC 650
ACCOUNTS PAYABLE 6
DEPT OF HEALTH
1000 NE 10TH ST

OKLAHOMA CITY, OK 73117-1207001

Ordered		Shipped	Product	Description	Unit Price	Extended Price
				RC306 H0100100116		
2	CTG	0	MCR0S	RIC TONER TYPE K1-CYAN (4CTG/CTN)3006,4006,4106 Ref # 887933	125.000	.00
2	CTG	2	MCR0P	RIC TONER TYPE K1-BLACK (4CTG/CTN)3006,4006,4106 Ref # 887914	38.800	77.60
2	CTG	2	MCR0Q	RIC TONER TYPE K1-YELLOW (4CTG/CTN)3006,4006,4106 Ref # 887921	125.000	250.00
2	CTG	2	MCR0R	RIC TONER TYPE K1-MAGENTA (4CTG/CTN)3006,4006,4106 Ref # 887927	125.000	250.00

ORDERED BY SUSAN WALDRON
EQUIPMENT ID 9685R
THANK YOU
TERRI MASSUCCI

RECEIVED
2000 NOV -3 A 10:26
FINANCIAL MANAGEMENT

431026573

X036124 PURCHASE DOCUMENT
000135NW197 ACCOUNT NO.
COMPLETE PARTIAL
400BT01 FUND NO.
42000 MATH CHECKED
3614A-X OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
Pleam 11-22-00
INVOICE APPROVED DATE

SUBTOTAL
577.60

TOTAL DUE
577.60

MEMO: THANK YOU FOR CHOOSING IKON OFFICE SOLUTIONS

PLEASE TEAR AT PERFORATION

THIS SHIPPING ORDER

must be legibly filled in, in Ink, in Indelible Pencil or in Carbon, and retained by the Agent.

RECEIVE, subject to the classifications and lawfully filed tariffs in effect on the date of the issue of this Shipping Order.

PAGE 01

If charges are to be pre-paid, write or stamp here, "To be Prepaid."

RECEIVED, subject to the classifications and lawfully filed tariffs in effect on the date of issue of this Bill of Lading.

DELIVERING CARRIER: UPS GROUND

VEHICLE OR CAR INITIAL:

SHIPPER'S NO.	DATE SHIPPED	CUSTOMER NUMBER
72683A	10/31/00	F92313

shipment moves between two ports by a carrier by water, the law requires that the bill of lading l state whether it is "carrier's or shipper's weight."

E - Where the rate is dependent on value, shippers are required to state specifically in writing agreed or declared value of the property.

agreed or declared value of the property is hereby specifically stated by the shipper to be not exceeding _____ per _____

is to certify that the above named articles are properly classified, described, packaged, marked, and labeled, are in proper condition for transportation, according to the applicable regulations of the Department of portation. _____ Shipper

bject to Section 7 of Conditions of applicable bill of lading, if this shipment is to be delivered to the consignee t recourse on the consignor, the consignor shall sign the following statement:
e carrier shall not make delivery of this shipment without payment of freight and all other lawful charges.

_____
(Signature of Consignor)

ot on Delivery $_____ and remit to:

NOTE: Where the rate is dependent on value, shippers are required to state specifically in writing the agreed or declared value of the property.

The agreed or declared value of the property is hereby specifically stated by the shipper to be not Exceeding _____

PER _____

† "The fibre boxes used for this shipment conform to the specifications set forth in the box maker's certification thereon, and all other requirements of Uniform Freight Classification."

† Shipper's imprint in lieu of stamp, not a part of bill of lading approved by Interstate Commerce Commission.

Received $ _____ to apply in prepayment of the charges on the property described hereon.

Agent or Cashier

Per _____

The signature here acknowledges only the amount pre-paid.

Charges Advanced: $ _____

). PKG.	QUANTITY	PRODUCT NO.	WAREHOUSE LOCATION	DESCRIPTION	WEIGHT	CLASS	✓
	0	MCR0S	ZF05C06	RIC TONER TYPE K1-CYAN			
		N80000	CTG	(4CTG/CTN) 3006,4006,4105			
				Ref # 887933			
		******2	BACKORDERED				
	0 2	MCR0P	ZF05C03	RIC TONER TYPE K1-BLACK	2.0		
		N80000	CTG	(4CTG/CTN) 3006,4006,4105			
				Ref # 887914			
	2	MCR0Q	ZF05C04	RIC TONER TYPE K1-YELLOW	2.0		
		N80000	CTG	(4CTG/CTN) 3006,4006,4105			
				Ref # 887921			
	2	MCR0R	ZF05C05	RIC TONER TYPE K1-MAGENTA	2.0		
		N80000	CTG	(4CTG/CTN) 3006,4006,4105			
				Ref # 887927			

ORDERED BY SUSAN WALDRON
EQUIPMENT ID 9635R
THANK YOU!
TERRI MASSUCCI

BO-2 MCR0P WILL SHIP ASAP

1556103100 PO # X036124 (918) 540-2481 TOTAL WEIGHT 6.0

CONSIGNED TO:

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

SHIPPER:

IKON OFFICE SOLUTIONS
728 HEISINGER DRIVE
SUITE D
JEFFERSON CITY MO 65109-0000

AGENT _____

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X036124	115505

FOR AGENCY USE WARRANT # 7510588 DATE: 12/01/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	932000000	125.00

CLAIM OF:
IKON OFC SOLUTIONS
230334400

1 1 5 5 0 5

FOR $ 125.00

AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No	TOTAL AMOUNT $
002		125.00

OSF-AUDITED BY

Receipt of Goods or Services Date (OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001108

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/06/2000	72683B	125.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3614AAAAAX 125.00

J/E XREF:

VENDOR: IKON OFC SOL/DOC SVCS (#11501)
ADDRESS: DEPT. 96-0075
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73196-007

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

11/22/2000
Date

Agency, Bd or Div. Use

IKON Office Solutions

SHIP TO INVOICE Page # 1

IKON Customer Service Cent
Call Toll Free 1-877-783-4566

SHIPPED TO

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

INVOICE INFORMATION

Customer #	J7A526	Dist. Code	00
Date	11/06/00	Order Date	10/31/00
Invoice #	72683B	Ship Date	11/06/00
PO Number	X036124	Shipped VIA	UPS GROUND

BILLING INFORMATION

115505pk

**********AUTO**MIXED AADC 650

DEPT OF HEALTH 9
1000 NE 10TH ST

OKLAHOMA CITY, OK 73117-1207001

Ordered		Shipped			Unit Cost	Extended Cost
				RC306 H0100100116		
2	CTG	1	MCR0S	RIC TONER TYPE K1-CYAN (4CTG/CTN)3006,4006,4106 Ref # 887933	125.000	125.00
2	CTG	2	MCR0P	RIC TONER TYPE K1-BLACK (4CTG/CTN)3006,4006,4106 Ref # 887914	38.800	77.60

230334400

~~431026573~~

RECEIVED
2000 NOV -9 P 3:22
FINANCIAL MANAGEMENT

X036124	000135NW97
PURCHASE DOCUMENT	ACCOUNT NO.
COMPLETE PARTIAL	400BT01
	FUND NO.
42000	3614A-X
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
Pleam 11-22-00	
INVOICE APPROVED	DATE

apply cm# 72683A - 77.60

125.00 SUBTOTAL ~~202.60~~

125.00 TOTAL DUE ~~202.60~~

MEMO: THANK YOU FOR CHOOSING IKON OFFICE SOLUTIONS

PLEASE TEAR AT PERFORATION

IKON Office Solutions

SHIP TO INVOICE Page # 1

IKON Customer Service Cen
Call Toll Free 1-877-783-456

SHIPPED TO

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

INVOICE INFORMATION

Customer #	J7A526	Dist. Code	00
Date	11/03/00	Order Date	11/03/00
Invoice #	72683A	Ship Date	11/03/00
PO Number	X036124		

BILLING INFORMATION

**********AUTO**MIXED AADC 650
AKA # J7A526 6
DEPT OF HEALTH
1000 NE 10TH ST

OKLAHOMA CITY, OK 73117-1207001

Ordered	Shipped	Product	Description	Price	Amount
2- CTG	2- MCROP	RC306 H0100100116	RIC TONER TYPE K1-BLACK (4CTG/CTN)3006,4006,4106 Ref # 887914	38.800	77.60-

applied to invoice 72683B

SUBTOTAL
77.60-

TOTAL DUE
77.60-

****** CREDIT MEMO ******

MEMO:

PLEASE TEAR AT PERFORATION

THIS SHIPPING ORDER

- must be legibly filled in, in ink, in indelible Pencil or in Carbon, and retained by the Agent.

RECEIVE, subject to the classifications and lawfully filed tariffs in effect on the date of the issue of this Shipping Order.

BH

If charges are to be pre-paid, write or stamp here, "To be Prepaid."

RECEIVED, subject to the classifications and lawfully filed tariffs in effect on the date of issue of this Bill of Lading.

DELIVERING CARRIER: UPS GROUND

VEHICLE OR CAR INITIAL: _____

SHIPPER'S NO.	DATE SHIPPED	CUSTOMER NUMBER
726838	1/06/00	F92313

the shipment moves between two ports by a carrier by water, the law requires that the bill of lading ell state whether it is "carrier's or shipper's weight."
OTE - Where the rate is dependent on value, shippers are required to state specifically in writing e agreed or declared value of the property.
e agreed or declared value of the property is hereby specifically stated by the shipper to be not exceeding _____ per _____

le is to certify that the above named articles are properly classified, described, packaged, marked, and labeled, d are in proper condition for transportation, according to the applicable regulations of the Department of ansportation. _____ Shipper

Subject to Section 7 of Conditions of applicable bill of lading, if this shipment is to be delivered to the consignee thout recourse on the consignor, the consignor shall sign the following statement:
The carrier shall not make delivery of this shipment without payment of freight and all other lawful charges.

_____
(Signature of Consignor)

llect on Delivery $_____ and remit to:

The property described below, in apparent good order, except as noted (contents and condition of contents of packages unknown), marked, consigned, and destined as indicated below, which said carrier (the word carrier being understood throughout this contract as meaning any person or corporation in possession of the property under the contract) agrees to carry to its usual place of delivery at said destination, if on its route, otherwise to deliver to another carrier on the route to said destination. It is agreed, as to each carrier of all or any of said property over all or any portion of said route to destination, and as to each party at any time interested in all or any of said property, that every carrier to be performing transportation shall be subject to all the terms and conditions of the Uniform Domestic Freight Bill of Lading set forth (1) in Official, Southern, Western and Illinois Freight Classifications in effect on the date hereof, if this is a rail or a rail-water shipment, or (2) in the applicable motor carrier classification or tariff if this is a motor carrier shipment.

Shipper hereby certifies that he is familiar with all the terms and conditions of the said bill of lading, including those on the back thereof, and hereby declares that the classification or rate at which property is described in accordance with the applicable classification, tariff, or agreement or otherwise lawfully entered into between the shipper and carrier, and that this shipment conforms to the specifications set forth in the box maker's certificate thereon, and all other requirements of the Uniform Freight Classification or rule or tariff of any other carrier or carriers over which the property is to be transported to its destination, which govern the transportation of this class or kind of property, and the said terms and conditions are hereby agreed to by the shipper and accepted for himself and assigns.

NOTE: Where the rate is dependent on value, shippers are required to state specifically in writing the agreed or declared value of the property.

The agreed or declared value of the property is hereby specifically stated by the shipper to be not Exceeding _____

PER _____

† "The fibre boxes used for this shipment conform to the specifications set forth in the box maker's certificate thereon, and all other requirements of Uniform Freight Classification."

† Shipper's imprint in lieu of stamp, not a part of bill of lading approved by Interstate Commerce Commission.

Received $ _____ to apply in prepayment of the charges on the property described hereon.

Agent or Cashier

Per _____

The signature here acknowledges only the amount pre-paid.

Charges Advanced: $ _____

NO. PKG.	QUANTITY	PRODUCT NO.	WAREHOUSE LOCATION	DESCRIPTION		WEIGHT	CLASS	✓
	1	MCR0S N80000	ZF05C06 CTG	RIC TONER TYPE K1-CYAN (4CTG/CTN) 3006,4006,4106 Ref # 887933		1.0		
		******1	BACKORDERED					
	2	MCR0P N80000	ZF05C03 CTG	RIC TONER TYPE K1-BLACK (4CTG/CTN) 3006,4006,4106 Ref # 887914		2.0		
				** COMPLETE **				
1048110600		PO #	X036124	(918) 540-2481 TOTAL WEIGHT		3.0		

Received 1/8/00

CONSIGNED TO:

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

SHIPPER:

IKON OFFICE SOLUTIONS
728 HEISINGER DRIVE
SUITE D
JEFFERSON CITY MO 65109-0000

AGENT _____

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X036124	115506

FOR AGENCY USE
WARRANT # 7510589 DATE: 12/01/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	932000000	125.00

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	125.00
003		OSF-AUDITED BY	

CLAIM OF:
IKON OFC SOLUTIONS
230334400

1 1 5 5 0 6

FOR
$ 125.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR NO.

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001109

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/07/2000	72683C	125.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3614AAAAAX 125.00

J/E XREF:

VENDOR: IKON OFC SOL/DOC SVCS (#11501)
ADDRESS: DEPT. 96-0075
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73196-007

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/22/2000

Title Date

Agency, Bd or Div. Use

IKON Office Solutions

SHIP TO INVOICE Page # 1

IKON Customer Service Cente
Call Toll Free 1-877-783-4566

SHIPPED TO

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

INVOICE INFORMATION

Customer #	J7A526	Dist. Code	00
Date	11/07/00	Order Date	10/31/00
Invoice #	72683C	Ship Date	11/07/00
PO Number	X036124	Shipped VIA	UPS GROUND

BILLING INFORMATION

115586 pr

**********AUTO**MIXED AADC 650

DEPT OF HEALTH 8
1000 NE 10TH ST

OKLAHOMA CITY, OK 73117-1207001

Ordered						
2	CTG	1	MCROS	RC306 H0100100116 RIC TONER TYPE K1-CYAN (4CTG/CTN)3006,4006,4106 Ref # 887933	125.000	125.00

431026573

RECEIVED
2000 NOV 14 P 12: 14
FINANCIAL MANAGEMENT

X036124	000135NW97
PURCHASE DOCUMENT	ACCOUNT NO.
	400BT01
COMPLETE PARTIAL	FUND NO.
42000	3614A-X
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
PReam 11-22-00	
INVOICE APPROVED	DATE

Office Solutions

SUBTOTAL
125.00

TOTAL DUE
125.00

MEMO: THANK YOU FOR CHOOSING IKON OFFICE SOLUTIONS

PLEASE TEAR AT PERFORATION

THIS SHIPPING ORDER

PAGE 01

Must be legibly filled in, in Ink, in Indelible Pencil or in Carbon, and retained by the Agent.

RECEIVE, subject to the classifications and lawfully filed tariffs in effect on the date of the issue of this Shipping Order.

If charges are to be pre-paid, write or stamp here, "To be Prepaid."

RECEIVED, subject to the classifications and lawfully filed tariffs in effect on the date of issue of this Bill of Lading.

DELIVERING CARRIER: UPS GROUND

VEHICLE OR CAR INITIAL:

SHIPPER'S NO.	DATE SHIPPED	CUSTOMER NUMBER
726830	11/07/00	F92313

The property described below, in apparent good order, except as noted (contents and condition of contents of packages unknown), marked, consigned, and destined as indicated below, which said carrier (the word carrier being understood throughout this contract as meaning any person or corporation in possession of the property under the contract) agrees to carry to its usual place of delivery at said destination, if on its route, otherwise to deliver to another carrier on the route to said destination. It is agreed, as to each carrier of all or any of said property over all or any portion of said route to destination, and as to each party at any time interested in all or any of said property, that every service to be performed hereunder shall be subject to all the terms and conditions of the Uniform Domestic Straight Bill of Lading set forth (1) in Official, Southern, Western and Illinois Freight Classifications in effect on the date hereof, if this is a rail or a rail-water shipment, or (2) in the applicable motor carrier classification or tariff if this is a motor carrier shipment.

Shipper hereby certifies that he is familiar with all the terms and conditions of the said bill of lading, including those on the back hereof, and both to the classification or tariff which governs the transportation of this shipment, and the said terms and conditions are hereby agreed to by the shipper and accepted for himself and assigns.

NOTE: Where the rate is dependent on value, shippers are required to state specifically in writing the agreed or declared value of the property.

The agreed or declared value of the property is hereby specifically stated by the shipper to be not Exceeding _____

PER _____

Received $ _____ to apply in prepayment of the charges on the property described hereon.

Agent or Cashier

Per _____

The signature here acknowledges only the amount pre-paid.

Charges Advanced: $ _____

the shipment moves between two ports by a carrier by water, the law requires that the bill of lading hall state whether it is "carrier's or shipper's weight."

IOTE - Where the rate is dependent on value, shippers are required to state specifically in writing he agreed or declared value of the property.

he agreed or declared value of the property is hereby specifically stated by the shipper to be not exceeding _____ per _____

his is to certify that the above named articles are properly classified, described, packaged, marked, and labeled, nd are in proper condition for transportation, according to the applicable regulations of the Department of ransportation. _____ Shipper

Subject to Section 7 of Conditions of applicable bill of lading, if this shipment is to be delivered to the consignee without recourse on the consignor, the consignor shall sign the following statement:
The carrier shall not make delivery of this shipment without payment of freight and all other lawful charges.

_____ (Signature of Consignor)

ollect on Delivery $_____ and remit to:

†"The fibre boxes used for this shipment conform to the specifications set forth in the box maker's certification thereon, and all other requirements of Uniform Freight Classification."

† Shipper's Imprint in lieu of stamp, not a part of bill of lading approved by Interstate Commerce Commission.

NO. PKG.	QUANTITY	PRODUCT NO.	WAREHOUSE LOCATION	DESCRIPTION		WEIGHT	CLASS	✓
	1	MCROS N80000	ZF05C06 CTG	RIC TONER TYPE K1-CYAN (4CTG/CTN)3006,4006,4105 Ref # 887933 ** COMPLETE **		1.0		
0934110700		PO # X036124		(918) 540-2481 TOTAL WEIGHT		1.0		

CONSIGNED TO:

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

SHIPPER:

IKON OFFICE SOLUTIONS
728 HEISINGER DRIVE
SUITE D
JEFFERSON CITY MO 65109-0000

AGENT _____

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X029633	114683

FOR AGENCY USE
WARRANT # 7469061 DATE: 11/17/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	932000000	119.00

CLAIM OF:
UNISOURCE WORLDWIDE, INC
135369500

1 1 4 6 8 3

FOR
$ 119.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		119.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001011

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/09/2000	64227990	119.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 361410355X 119.00

J/E XREF:

VENDOR: UNISOURCE WORLDWIDE, INC
ADDRESS: P O BOX 910303
ADDRESS:
CITY/ST/ZIP: DALLAS TX 753910303

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/15/2000

Title Date

Agency, Bd or Div. Use

114683-PK

unisource

UNISOURCE WORLDWIDE INC-OKCITY
P.O. BOX 910303 (75391)
DALLAS, TX. 75391

Invoice No.	Invoice Date	Account No.
[redacted]	[redacted]/09/2000	191664
Due Date	**Total Amount Due**	**Enter Amount Paid**
11/08/2000	119.00	

NM0000736 - 64

OKLAHOMA STATE DEPT OF HEALTH
PROCUREMENT DIVISION
1000 NE 10TH ST
OKLAHOMA CITY OK 73117-1207

UNISOURCE WORLDWIDE INC-OKCITY
P.O. BOX 910303 (75391)
DALLAS, TX. 75391

Remit Payment To This Address

Detach and return this portion with remittance. Retain bottom portion for your records.

SHIP TO
OTTAWA COUNTY HEALTH DEPT.
ATTN: SUSAN WALDREN
1930 NORTH ELM
MIAMI,OK 74354-0000

SOLD TO
OKLAHOMA STATE DEPT OF HEALTH
PROCUREMENT DIVISION
1000 NE 10TH ST
OKLAHOMA CITY OK 73117-1207

Page 1 OF 1

Invoice No.	Invoice Date	Customer P.O.	Order Date	Terms
84227990	10/09/200[redacted]		10/02/2000	2% 10TH PROX., NET THEREAFTER

Product No.	Product Description/References	Quantity Shipped	Unit Meas.	Unit Price	Unit Meas.	Extended Price	Tax
5735601	8 1/2X11 10M 20# WHITE PER CTN GEOCYCLE RECYCLED XEROGRAPHIC 226000 GEORGIA PACIFIC CORP FQP	5	CT	23.80	CT	119.00	N
NFREIGHT	FREIGHT * SHIPPED 10-2-00 BEAVER EXP B/L# 9243714	1	EA		EA		N

135369500

X029633 PURCHASE DOCUMENT
000135NW97 ACCOUNT NO.
001 COMPLETE PARTIAL
400BT01 FUND NO.
42000 MATH CHECKED
3614103SSX OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
PReam 11-13-00 INVOICE APPROVED DATE

FINANCIAL MANAGEMENT

RECEIVED
2000 OCT 17 P 4:12

Discount allowed on	Discount Date	Delivery Information:	Taxable Sales	Total Tax
.00	00/00/0000		.00	.00
	Discount Amount .00	Time: Date:		Total Amount Due 119.00

unisource

Legend				
BD = Bundle	CS = Case	EV = Envelope	PK = Package	SK = Skid
BG = Bag	CT = Carton	GL = Gallon	PL = Pail	ST = Set
BL = Bale	CW = Hundred Wt	LB = Pounds	RL = Roll	TB = Tube
BX = Box	DR = Drum	LF = Linear Feet	RM = Ream	U = Unit
C = Hundred	DZ = Dozen	M = Thousand	SF = Square Feet	Y = Taxable
	EA = Each	MS = Thousand SqFt	SH = Sheet	N = Non Taxable

For Invoice Inquiries, Call

Service charges of 1.5% per month or the maximum permitted by applicable law, whichever is lower, will be assessed on all open items on the last day of the second month following the date of the invoice and included on the month-end customer statement.

Goods and services covered by this invoice are being sold only in accordance with the terms and conditions contained herein and on the reverse side hereof, and in Seller's quotation or acknowledgement if any, including the terms and conditions printed on the reverse side thereof. By accepting delivery of the goods or services covered hereby, Buyer waives all terms and conditions contained in it's purchase order or other documents which are different from or additional to those contained herein and on the reverse side hereof and all such different or additional terms and conditions shall be null and void.

K0436 (6-98)

Ream, Patti J.

From: Fouquet, Sonja F.
Sent: Wednesday, November 15, 2000 9:17 AM
To: Ream, Patti J.
Subject: FW: Unisource PO X029633

If you want to work your way through all of this you can, but the bottom (actually the top) line is that all five cases of paper were received by Ottawa County Blood Lead.

-----Original Message-----
From: **Perry, Pamela S.**
Sent: Wednesday, November 15, 2000 8:56 AM
To: Fouquet, Sonja F.
Cc: Ream, Patti J.
Subject: FW: Unisource PO X029633

Ottawa Co. did receive all 5 cases of the paper. It is ok to pay the invoice.

-----Original Message-----
From: Murphy, Romain
Sent: Tuesday, November 14, 2000 12:15 PM
To: Perry, Pamela S.
Subject: RE: Unisource PO X029633

Nancy Horton from Ottawa Co says the received 4 cases. I am double checking the amount with her. Will let you know.

-----Original Message-----
From: Perry, Pamela S.
Sent: Tuesday, November 14, 2000 8:25 AM
To: Murphy, Romain
Subject: FW: Unisource PO X029633

Here is another one.

-----Original Message-----
From: Fouquet, Sonja F.
Sent: Monday, November 13, 2000 10:44 AM
To: Perry, Pamela S.
Subject: FW: Unisource PO X029633

Same as before. Ottawa County Blood Lead

-----Original Message-----

From: **Ream, Patti J.**
Sent: Monday, November 13, 2000 10:26 AM
To: Fouquet, Sonja F.
Subject: Unisource PO X029633

I have an invoice dated 10-09-00 for 5 cartons of 8 ½ x 11 Geocycle Recycled xerographic paper. Did we receive teh paper?

Ream, Patti J.

From: Perry, Pamela S.
Sent: Wednesday, November 15, 2000 8:56 AM
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Cc: Ream, Patti J.
Subject: FW: Unisource PO X029633

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OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X029346	112348

FOR AGENCY USE
WARRANT # 7400535 DATE: 10/27/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3721	932000000	100.00

CLAIM OF:
SOUTH CENTRAL INDUSTRIES, INC
731138726

FOR
$ 99.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		99.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001009

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/09/2000	2671	99.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3721AAAAAX 100.00

J/E XREF:

VENDOR: SOUTH CENTRAL INDUSTRIES, INC
ADDRESS: 130 N. LOUISE
ADDRESS:
CITY/ST/ZIP: SHAWNEE OK 748023766

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

10/25/2000
Date

Agency, Bd or Div. Use

112348 PR

SOUTH CENTRAL INDUSTRIES, INC.
P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer [redacted] Phone
Order No [redacted] Date [redacted]

Name Okla State Health Dept. of Health
Address 1000 N.E. 10th Street OKC

SOLD BY	CASH	C. O. D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT	

Quantity	DESCRIPTION	PRICE	AMOUNT	
2cs	0475-41-44-150	50.00	100	00
	Latex P.F. Ultra medium			
	100/box 10box/case			
	Thank You!			
			[redacted]	
	Minus 1% levy	TAX	1	00
		TOTAL	99	00

JE-010350

CODE 15814

ALL claims and returned goods MUST be accompanied by this bill.

Rec'd by _____

[redacted]

Thank You

PRINTED IN U.S.A.

731138726

X024346	000135NW97
PURCHASE DOCUMENT	ACCOUNT NO.
001	40[illegible]01
COMPLETE PARTIAL	FUND NO.
42000	3721A-X
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
Pream 10-24-00	
INVOICE APPROVED	DATE

OTTAWA CHD
ATTN: SUSAN WALDRON
1930 N. ELM

SOUTH CENTRAL INDUSTRIES, INC.
P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer's Order No. X029346 Phone No. _____ Date 10-9-00

Name Okla State Health Dept of Health

Address 1000 N.E. 10th Street OKC

SOLD BY	CASH	C. O. D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

Quantity	DESCRIPTION	PRICE	AMOUNT	
2cs	0475-41-44-150	50.00	100	00
	Latex P.F. Ultra medium			
	100/box 10box/case			
	Thank You!			
	Mrmx 1% levy		100	00
		TAX	1	00
		TOTAL	99	00

ALL claims and returned goods MUST be accompanied by this bill.

Rec'd by _____

Thank You

PRINTED IN U.S.A.

RECEIVED
OCT 09 2000
SHIPPING & RECEIVING

RECEIVED
2671

[redacted]

** AGENCY COPY ** ' SVC CHF: NW

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X029947	115312

FOR AGENCY USE
WARRANT # 7490469 DATE: 11/27/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3721	939170000	32.11

CLAIM OF:
HOME DEPOT
581853319

1 1 5 3 1 2

FOR
$ 32.11

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	32.11
	YES	OSF AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001031

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/31/2000	000580/82832	32.11

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3721AAAAAX 32.11

J/E XREF:

VENDOR: HOME DEPOT/GECF
ADDRESS: P.O. BOX 9903
ADDRESS:
CITY/ST/ZIP: MACON GA 312979903

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/21/2000

Title Date

Agency, Bd or Div. Use

11/3/00 DL

THE HOME DEPOT 3902
3040 N.W. 59TH STREET
OKLAHOMA CITY, OK. 73112 (405)843-5008

SALE 3902 00028 13806 32 504 10/31/00 03:21 PM

5608

733417107405	19"TOOLBOX	6.94
039800055842	BATTERY	3.49
076174644579	SC DR SET	5.49
038313010201	TRANSPLANT	4.96
076174100990	KNIFE	3.96
076174332124	POWERLOCK	7.27
	SUBTOTAL	32.11
32.11	TAX OK 7.875	~~2.53~~
	TOTAL	~~$34.64~~
XXXXXXX2413	HOME DEPOT	~~34.64~~
AUTH #/INVOICE 000580/8283286		TA
P.O.#/JOB NAME: X029947		32.11

OKLAHOMA STATE HEALT
REQUIRED PO

CUSTOMER COPY

3902 28 13806 10/31/00 5608

HAVE A NICE DAY! 10/31/00

WWW.HOMEDEPOT.COM

Items 1,2,3,4,6,+7

X029947

ACCOUNT NO. 4004101
FUND NO. 5101 B-X
OBJECT CODE 5224
CLAIM NUMBER
DATE 11-6-00

Item 005 Returned 11/3/00

THE HOME DEPOT 3902
3040 N.W. 59TH STREET
OKLAHOMA CITY, OK. 73112 (405)843-5008

SALE 3902 00028 13814 32 504 10/31/00 03:35 PM

5608

051751029789	26IN STEPS	~~24.97~~
24.97	TAX OK 7.875	~~1.97~~
	TOTAL	$26.94
XXXXXXX2413	HOME DEPOT	26.94
AUTH #/INVOICE 000572/8283287		TA
P.O.#/JOB NAME: X029947		

OKLAHOMA STATE HEALT
REQUIRED PO

CUSTOMER COPY

3902 28 13814 10/31/00 5608

HAVE A NICE DAY! 10/31/00

WWW.HOMEDEPOT.COM

THE HOME DEPOT 3902
3040 N.W. 59TH STREET
OKLAHOMA CITY, OK. 73112 (405)843-5008

RETURN 3902 00025 65117 22 [illegible] 11/02/00 03:18 PM

** REFUND **

* ORIG REC: 3902 028 13814 10/31/00 *

051751029789	26IN STEPS	-24.97
24.97	TAX OK 7.875	-1.97
	TOTAL	-$26.94
XXXXXXX2413	HOME DEPOT CR	-26.94
	INVOICE 6250601	TA
P.O.#/JOB NAME:	X029947	

TU

** REFUND **

CUSTOMER COPY

HAVE A NICE DAY!

WWW.HOMEDEPOT.COM

7901 546241 3 L042938

1. Vendor's Office Copy

Page 1

State of Oklahoma
State Department of Health
Purchase Order

PO# X029947

BUYER - LMW (405-271-6617)

1800-562-5571

Date Issued: 09/29/00	Regn.#: L030228	Agency Regn.#: 01-01918	Terms: NET	Delivery Date: 10/10/2000

To: 581853319
ATTN LYNN MIKLES
HOME DEPOT INC 3902
3030 NW 59 TH
OKLAHOMA CITY OK 73112

Ship To: 34001
OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: SHIPPING & RECEIVING
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

Charge & Invoice To: 34000
OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

Item	Quantity	Unit	Commodity Code	Description	Unit Price	Amount
001	1.00	EA	0905-49-24-295	Tool Box 19" Homer Orange Box Code# 498-551	6.940000	6.94
002	1.00	EA	0590-42-20	Tape Measure Power-Lock 1/2 x 12 FT Code# 185-809	7.270000	7.27
003	1.00	EA	0445-42	Utility Knife Code# 181-691	3.960000	3.96
004	1.00	EA	0285-95-99-015	Scredriver 6 PC Set Code# 185-171	5.490000	5.49
005	1.00	EA	0450-52-05	Step ladder, aluminum RETURNED Model 150B Code# 189-818	14.720000	14.72
006	1.00	EA	0445-61-80	Shovel, Comfort Transplanter Code# 544-547	4.960000	4.96
007	1.00	EA	0450-32-11	Flashlight Industrial AA Code# 441-638	3.490000	3.49

Continued, Next Page ...

Prices exclusive of Federal and State Taxes. Prices are FOB destination unless stated otherwise.
VENDORS READ AND FOLLOW CLOSELY:

1. This order void one year from date of issuance.
2. The above order is issued in conformity with your quotation and constitutes a contract.
3. If payment is received in excess of 45 days after submitting proper invoice, vendor may be be entitled to claim interest penalty. For a copy of these regulations contact OFFICE OF STATE FINANCE Room 122, State Capitol Bldg, OKC, OK. 73105

signed
Director/Designee
title

1. Vendor's Office Copy

State of Oklahoma
State Department of Health
Purchase Order

BUYER - LMW

PO# X029947

Date: 09/29/00 Reqn. # L030228 Agency Reqn # 01-01918 Page # 2

Item	Quantity	Unit	Commodity Code	Description	Unit Price	Amount

Total Amount $46.83

3211

TERMS:

AGENCY CONTACT: PROCUREMENT (405)271-4042
PROGRAM CONTACT: LINDA WILSON/MCH
(405)271-4470

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X035458	116555

FOR AGENCY USE
WARRANT # 7530546 DATE: 12/07/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	000000000	276.00

CLAIM OF:
TAYLOE PAPER CO
730477150

1 1 6 5 5 5

FOR
$ 276.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant _____

WARRENT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	
001		OSF AUDITED BY	276.00

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001024

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/02/2000	3013378-00	276.00

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 3614AAAAAX 276.00

J/E XREF:

VENDOR: TAYLOE PAPER COMPANY
ADDRESS: DEPT NO 146
ADDRESS: PO BOX 21228
CITY/ST/ZIP: TULSA OK 741211228

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

Date 12/05/2000

Agency, Bd or Div. Use

Document: Invoice

Cust #: 600495

Salesman: 999

Invoice Date: 11/02/00

Order #: 3013378-00

PO Date: 10/24/00

PO #: X035458

Page #: 1

Ship To: OTTAWA CO HEALTH DEPT
1930 N ELM
ATTN SUSAN WALDRON
MIAMI, OK 74354

Remit To: Tayloe Paper Company
Dept# 146
PO Box 21228
Tulsa, OK 74121-1228

Instructions:

Via: Tayloe Truck

Ship Point: Tayloe Joplin Warehouse

Bill To: OKLAHOMA STATE DEPT. OF HEALTH
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117

Shipped: 11/02/00

Terms: 1%/10 Net 30

Product / Lot And Description	Quantity Ordered	Quantity B.O.	Quantity Shipped	Qty. UM	Unit Price	Price UM	Discount Multiplier	Amount (Net)
1 26864 8 1/2X11 12M 24 RADIANT WHITE HAMM'L LASER PRINT	20000	0	20000	EA	13.80	M	0.00	276.00
1 Lines Total	Qty Shipped Total		20000			Total Invoice Total		276.00 276.00

Last Page

Cash Discount 2.76 If Paid By 11/12/00

Ream, Patti J.

From: Fouquet, Sonja F.
Sent: Tuesday, December 05, 2000 8:25 AM
To: Ream, Patti J.
Subject: FW: GRANT CLOSE OUT 12/05/00

Okay to pay Tayloe X035458 for $276.00.

-----Original Message-----
From: Perry, Pamela S.
Sent: Monday, December 04, 2000 8:32 AM
To: Fouquet, Sonja F.
Subject: RE: GRANT CLOSE OUT 12/05/00

We didn't have a packing slip on this one, just confirmation of receipt via e-mail from Ottawa Co.

-----Original Message-----
From: Fouquet, Sonja F.
Sent: Friday, December 01, 2000 2:29 PM
To: Perry, Pamela S.
Subject: FW: GRANT CLOSE OUT 12/05/00

I thought I took packing slips down to her on this one. Three parts? If not did we get the items?

-----Original Message-----
From: Ream, Patti J.
Sent: Friday, December 01, 2000 2:18 PM
To: Fouquet, Sonja F.
Subject: RE: GRANT CLOSE OUT 12/05/00

I don't have the packing slips - Can you confirm for me that all items were received?

-----Original Message-----
From: Fouquet, Sonja F.
Sent: Friday, December 01, 2000 12:07 PM
To: Ream, Patti J.
Cc: Perry, Pamela S.; Morley, Greg; Truitt, Mike D.
Subject: GRANT CLOSE OUT 12/05/00

Patti,

I have a grant close out 12/05/00 and I believe you have a TAYLOE -X035458- invoice and packing slips for the entire amount, $276.00. Funding 400BT01_000135NW97_42000 object code 3614.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X029634	112054

FOR AGENCY USE
WARRANT # 7390497 DATE: 10/25/2000

CLAIM OF:
BEYOND TECHNOLOGY
841099877

1 1 2 0 5 4

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3614	000000000	222.08

FOR
$ 222.08

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	222.08
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001004

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/09/2000	67436	222.08

THIS SPACE FOR AGENCY USE

400BT01 000135NW97 361410175X 222.08

J/E XREF:

VENDOR: BEYOND TECHNOLOGY
ADDRESS: 1030 WEST ELLSWORTH
ADDRESS:
CITY/ST/ZIP: DENVER CO 80223

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

10/23/2000

Title Date

Agency, Bd or Div. Use

112054 pre

Beyond Technology
1030 West Ellsworth
Denver, Colorado 80223
(303) 629-0252
Fax: (303) 623-4843
www.beyondtec.com

INVOICE

INVOICE NUMBER: [illegible]

INVOICE DATE:
CUSTOMER NUMBER: 10-09-00

Distributor of Fine OEM/Compatible Ribbons, Facsimile Products, Laser Supplies

QUANTITY	ITEM NO.	DESCRIPTION	UNIT PRICE	NET AMOUNT
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[illegible]

X029634	000135NW97
PURCHASE DOCUMENT	ACCOUNT NO.
001	400BT01
COMPLETE PARTIAL	FUND NO.
42000	36410175X
[illegible]	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
Pream 10-20-00	
INVOICE APPROVED	DATE

RECEIVED
2000 OCT 16 A 10:48
FINANCIAL MANAGEMENT

FED. I.D. [illegible]

TERMS: NET 15 DAYS

BILL TO:

ATTN: ACCOUNTS [illegible]
OKLAHOMA STATE DEPT. OF HEALTH
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK [illegible]

P.O. #: 029634

CHECK OUT OUR NEW WEB SITE
[illegible]
ALL YOUR COMPUTER NEEDS ON ONE WEB SITE

SUB-TOTAL	[illegible]
FRT/HANDLING	[illegible]
STATE SALES TAX	[illegible]
COUNTY/STD SALES TAX	[illegible]
CITY SALES TAX	[illegible]
TOTAL	[illegible]

TERMS:
If invoice is not paid within 30 days of billing date, total price will be subject to a finance charge of 1-1/2% per month, an annual rate of 18%. No shipments will be made to any account 45 days past due. It is agreed that the partnership and/or corporation shall be responsible for all collection costs, including attorney fees, should it become necessary for BTC to commence legal action to collect monies owed by said partnership and/or corporation.

SHIP TO:

ATTN: ACCOUNTS [illegible]
OKLAHOMA STATE DEPT. OF HEALTH
[illegible]
[illegible]

PICKING SHEET

ORDER NUMBER: 0007433
CUSTOMER NO: BEY001

ORDER DATE: 10/02/00
SALESPERSON: JF

SOLD BY:
BEYOND TECHNOLOGY
8936 Comanche Ave.
Chatsworth, CA 91311

SHIP TO:
OKLA. ST. DEPT. OF HEALTH
1000 N.E 10TH ST.
PO X029634
OKLAHOMA CITY, OK 73117

CONFIRM TO: BEYOND TECHNOLOGY

CUSTOMER P.O.	SHIP VIA	F.O.B.	TERMS
10-10R	UPS GROUND		NET 30 DAYS

LOCATION	ITEM NO.	UNIT	ORDERED	SHIPPED	BACK ORD
4 5C	H11-6321-220	EACH	4		
L5000/L5500 (FX2) TONER-CANON					

SHIP TO:
OTTAWA CHD
SUSAN WALDRON
1930 N. ELM
MIAMI, OK
74354

RECEIVED
OCT 0 4 2000
SHIPPING & RECEIVING

WB# 1937396

RECEIVED

BOXES 13

Time And Effort Cost
Cost Accumulation Schedule

December 27, 2000
Prepared By _____

Grant Name: Conduct Site Specific Activity
Grant Number U50 / ATU686520-02
Grant Period 09/29/1999 TO 09/28/2000
Program Code 391

==ProgCost==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
199910	29.95	68.29	0.00	314.40
199911	33.83	113.54	0.00	460.20
199912	57.01	111.23	0.00	365.45
200001	82.48	85.09	0.00	570.89
200002	80.00	113.40	0.00	563.74
200003	49.32	90.19	0.00	448.55
200004	37.03	55.69	0.00	288.52
200005	48.98	95.39	0.00	399.42
200006	54.81	75.95	0.00	577.69
200007	55.18	23.25	0.00	259.18
200008	60.18	65.22	0.00	661.65
200009	49.33	93.79	0.00	461.43
Total	**638.10**	**991.03**	**0.00**	**5,371.10**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
199910	4.17	9.51	0.00	43.76
199911	3.43	11.53	0.00	46.73
199912	6.65	12.97	0.00	42.62
200001	12.24	12.63	0.00	84.73
200002	8.67	12.29	0.00	61.10
200003	5.38	9.83	0.00	48.90
200004	4.02	6.04	0.00	31.30
200005	5.67	11.03	0.00	46.21
200006	5.62	7.79	0.00	59.24
200007	5.82	2.45	0.00	27.34
200008	6.13	6.65	0.00	67.44
200009	5.34	10.15	0.00	49.96
Total	**73.14**	**112.87**	**0.00**	**609.33**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
34.12	77.80	0.00	358.16
37.26	125.07	0.00	506.93
63.66	124.20	0.00	408.07
94.72	97.72	0.00	655.62
88.67	125.69	0.00	624.84
54.70	100.02	0.00	497.45
41.05	61.73	0.00	319.82
54.65	106.42	0.00	445.63
60.43	83.74	0.00	636.93
61.00	25.70	0.00	286.50
66.31	71.87	0.00	729.09
54.67	103.94	0.00	511.39
711.24	**1,103.86**	**0.00**	[redacted]

Worker's Comp
9/29/1999 to 9/28/2000

Fund	Obj Code	Ref #	Amount
400BT00	1231	D63152	1.38
400BT00	1231	D68648	1.38
400BT00	1231	E03603	1.38
400BT00	1231	E09583	1.38
400BT00	1231	D56411	2.35
400BT00	1231	D61143	2.35
400BT00	1231	003640	(2.35)
400BT00	1231	D25764	47.59
400BT00	1231	D31104	47.59
400BT00	1231	D36280	47.59
400BT00	1231	D42024	47.59
400BT00	1231	D44630	(47.59)
400BT00	1231	D47184	47.59
400BT00	1231	D49591	(47.59)
400BT00	1231	D56328	47.59
400BT00	1231	D60585	47.59
400BT00	1231	D63371	47.59
400BT00	1231	D68865	47.59
400BT00	1231	E03798	47.59
400BT00	1231	E09785	47.59
400BT00	1231	D26348	51.77
400BT00	1231	D31688	51.77
400BT00	1231	D36845	56.88
400BT00	1231	D42591	51.77
400BT00	1231	D45218	(56.88)
400BT00	1231	D47765	56.88
400BT00	1231	D50164	(51.77)
400BT00	1231	D56419	51.77
400BT00	1231	D61170	51.77
400BT00	1231	D63962	51.77
400BT00	1231	D69449	51.77
400BT00	1231	E04328	51.77
400BT00	1231	E10363	51.77
400BT00	1231	D30808	2.56
400BT00	1231	D35990	2.84
400BT00	1231	D41745	2.84
400BT00	1231	D44333	(2.84)
400BT00	1231	D46890	2.84
400BT00	1231	D49308	(2.84)
400BT00	1231	D56272	2.84
400BT00	1231	D60293	2.84
400BT00	1231	D63075	1.94
400BT00	1231	D26337	54.40
400BT00	1231	D31677	54.40
400BT00	1231	D36834	59.51
400BT00	1231	D42580	54.40
400BT00	1231	D45207	(59.51)
400BT00	1231	D47754	59.51
400BT00	1231	D50153	(54.40)
400BT00	1231	D56415	54.40
400BT00	1231	D61158	54.40
400BT00	1231	D63950	54.40
400BT00	1231	D69438	54.40
			1,306.15
400BT01	1231	E15312	1.41
400BT01	1231	E20584	1.41
400BT01	1231	E27386	1.41
400BT01	1231	E15517	49.44
400BT01	1231	E20796	49.44
400BT01	1231	E27630	58.57
400BT01	1231	E16099	53.82
400BT01	1231	E21383	53.82
400BT01	1231	E28290	53.82
400BT01	1231	E21035	4.24
400BT01	1231	E27895	3.20
			330.58
		Total Worker's Comp	**$ 1,636.73**

INDIRECT COST SCHEDULE

Conduct Site Specific Activity
U50 / ATU686520-02
09/29/1999 to 09/28/2000

	Salary	Rate	Total
SFY - 2000			
On-Site	4,380.43	16.70%	731.53
Off-Site	55,978.34	14.70%	8,228.82
SFY - 2001			
On-Site	1,694.44	14.40%	244.00
Off-Site	23,049.53	7.80%	1,797.86
		Total Indirect Cost	11,002.21
		Federal Share of Indirect Cost	11,002.21

PERSONAL IDENTIFIER(S) REDACTED

STATE AND LOCAL RATE AGREEMENT

EIN #: 1736017987C4

DATE: May 31, 2000

DEPARTMENT/AGENCY:
Oklahoma State Department of Health
P.O. Box 53551
1000 NE Tenth St.
Oklahoma City OK 73117-1299

FILING REF.: The preceding Agreement was dated May 24, 1999

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE(%)	LOCATIONS	APPLICABLE TO
FIXED	07/01/00	06/30/01	14.4	On Site	All Programs
FIXED	07/01/00	06/30/01	7.8	Off Site	All Programs
PROV.	07/01/01	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending June 30, 2001.		

*BASE:
Direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits.

STATE AND LOCAL RATE AGREEMENT

EIN #: 1736017987C4

DATE: May 24, 1999

DEPARTMENT/AGENCY:
Oklahoma State Department of Health
P.O. Box 53551
1000 NE Tenth St.
Oklahoma City OK 73117-1299

FILING REF.: The preceding Agreement was dated June 5, 1998

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE(%)	LOCATIONS	APPLICABLE TO
FIXED	07/01/99	06/30/00	16.7	On Site	All Programs
FIXED	07/01/99	06/30/00	14.7	Off Site	All Programs
PROV.	07/01/00	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending June 30, 2000.		

*BASE:
Direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

DATE 6/26/2003

Oklahoma State Department of Health
State Cooperative Agreement Expenditures (SCA)
Superfund site (60BE), Tar Creek (Ottawa County) (OU2)
Ottawa County, Oklahoma

For the period 9/29/00 to 9/28/01

Personnel	$ 138,379.86
Fees	$ 4,239.47
Travel	$ 6,497.80
Equipment	$ -
Other	$ 56,180.33
Indirect	$ 10,611.36
TOTALOKLAHOMA SCA COSTS	$ 215,908.82

PERSONAL IDENTIFIER(S) REDACTED

Oklahoma State Department of Health
Leslie M. Beitsch, MD
Commissioner of Health

June 13, 2003

Betty Jones
Cost Recovery Team Leader
1825 Century Boulevard
Mail Stop E-28 (OPOM)
Atlanta, Georgia 30345

RE: Tar Creek Documentation Requested for Cost Recovery (9/29/2000 to 9/28/2001)

Dear Ms. Jones,

In response to your request for Cost Recovery documentation I am sending you the enclosed information. This information covers the period 9/29/2000 to 9/28/2001 for the Program to Build Capacity to Conduct Site-Specific Environmental Health Education Monitoring Activities.

I have this documentation grouped with the same categories identified in the letter from Ken Cadaret to Richard Haj dated June 6, 2002. I have included all costs for this period that we can support with documentation.

If you have any additional question regarding the documentation provided please feel free to contact me at (405) 271-4042.

Respectfully,

Michael D. Truitt
Grants Supervisor
Financial Management Service

Board of Health
Ron L. Graves, DDS, President
John B. Carmichael, DDS
Jay A. Gregory, MD
Haskell L. Evans, Jr, RPh, Vice President
Gordon H Deckert, MD
Ron Osterhout
Glen E. Diacon, Jr. MD, -Treasurer
Dan H. Fieker, DO
Ann A. Warn, MD

1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us
An Equal Opportunity Employer

TOTAL COSTS
9/29/2000 to 9/28/2001

Personnel	$ 138,379.86
Fees	4,239.47
Travel	6,497.80
Equipment	-
Other	56,180.33
IDC	10,611.36
Total	$ 215,908.82

PERSONAL IDENTIFIER(S) REDACTED

PERSONNEL

9/29/2000 to 9/28/2001

TE005	122,571.79
PGM 301	15,973.37
Sub-Total	138,545.16
Adjustments to TE005	(165.30)
Total Personnel	$ 138,379.86

TE005 are the direct costs and PGM 301 are the allocated costs. PGM 301 is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

REPORT-ID=TE005 — OKLAHOMA DEPARTMENT OF HEALTH — DATE RUN 05/29/2003

ALPHA SORT — LABOR DISTRIBUTION REPORT(PROGRAM CODE 391 ONLY) — PAGE 1

PERIOD 10/01/2000 THRU 09/30/2001

NAME (LAST)	F	PROG	ACT	TASK	OUT	SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
ARNOLD	N	391	021	000			2.01	0.05	2.06	100.0	22.37	5.57	27.94
TOTAL							2.01	0.05	2.06	100.0	22.37	5.57	27.94
BUCK	J	391	010	000			0.67	0.10	0.77	0.4	9.37	2.83	12.20
		391	021	000			59.66	13.53	73.19	99.6	1002.79	295.84	1298.63
SUBTOTAL		391					60.33	13.63	73.96	100.0	1012.16	298.67	1310.83
TOTAL							60.33	13.63	73.96	100.0	1012.16	298.67	1310.83
CADARET	K	391	021				48.00	15.42	63.42	36.0	1504.98	419.13	1924.11
		391	021	000			144.04	20.63	164.67	64.0	3569.13	1083.36	4652.49
SUBTOTAL		391					192.04	36.05	228.09	100.0	5074.11	1502.49	6576.60
TOTAL							192.04	36.05	228.09	100.0	5074.11	1502.49	6576.60
CORNELL	K	391	010	001			70.01	19.55	89.56	48.7	2113.38	516.22	2629.60
		391	411	001	19	18	96.32	27.51	123.83	67.3	2852.95	700.53	3553.48
		391	412	001	4	4	3.33	1.99	5.32	2.9	119.73	29.69	149.42
		391	412	002			1.33	0.00	1.33	0.7	29.93	7.42	37.35
		391	425	001			1.01	1.94	2.95	1.6	63.60	15.77	79.37
		391	426	001	18	4	38.66	5.24	43.90	23.9	1024.26	250.54	1274.80
		391	427	001			9.35	3.67	13.02	7.1	276.87	68.65	345.52
		391	427	002			2.00	0.23	2.23	1.2	52.38	12.99	65.37
		391	431	001			91.72	18.58	110.30	59.9	2670.92	647.68	3318.60
		391	441	001			13.70	5.06	18.76	0.0	404.09	101.13	505.22
SUBTOTAL		391					327.43	83.77	411.20	213.3	9608.11	2350.62	11958.73
TOTAL							327.43	83.77	411.20	213.3	9608.11	2350.62	11958.73
FOUQUET	S	391	021				18.36	5.47	23.83	100.0	444.88	121.82	566.70
TOTAL							18.36	5.47	23.83	100.0	444.88	121.82	566.70
FROST	T	391	010				2.00	0.31	2.31	1.3	49.86	12.28	62.14
		391	010	000			7.33	1.01	8.34	4.8	180.28	45.17	225.45
		391	020				2.00	0.67	2.67	1.5	61.37	15.11	76.48
		391	020	000			44.34	6.72	51.06	29.6	1127.63	281.21	1408.84
		391	021				7.34	3.47	10.81	6.3	245.47	60.44	305.91
		391	021	000			6.36	1.42	7.78	56.5	180.26	44.70	224.96
SUBTOTAL		391					69.37	13.60	82.97	100.0	1844.87	458.91	2303.78
TOTAL							69.37	13.60	82.97	100.0	1844.87	458.91	2303.78
HOPKINS	T	391	010				2.34	0.06	2.40	1.8	23.11	9.27	34.38
		391	020				379.01	86.48	465.49	344.8	4065.96	1501.60	5567.56
		391	020	000			553.67	138.32	691.99	512.6	5186.20	1981.22	7167.42
		391	021				9.00	2.12	11.12	0.0	93.45	34.52	127.97
SUBTOTAL		391					944.02	226.98	1171.00	859.2	9370.72	3526.61	12897.33
TOTAL							944.02	226.98	1171.00	859.2	9370.72	3526.61	12897.33

REPORT-ID=TE005 — OKLAHOMA DEPARTMENT OF HEALTH — DATE RUN 05/29/2003

ALPHA SORT — LABOR DISTRIBUTION REPURT(PROGRAM CODE 391 ONLY) — PAGE 2

PERIOD 10/01/2000 THRU 09/30/2001

NAME (LAST)	F	PROG	ACT	TASK	OUT	SES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
HORTON	N	391	010				31.98	1.80	33.78	19.3	546.29	147.44	693.73
		391	010	000			95.59	8.90	104.49	59.8	1693.04	460.39	2153.43
		391	020				417.69	32.84	450.53	258.0	7326.08	1962.61	9288.69
		391	020	000			1283.00	141.81	1424.81	815.8	22879.33	6220.66	29099.99
		391	021				38.67	1.36	40.03	22.9	635.88	172.34	808.22
		391	021	000			20.02	1.71	21.73	0.0	354.47	96.63	451.10
SUBTOTAL		391					1886.95	188.42	2075.37	175.8	33435.09	9060.07	42495.16
TOTAL							1886.95	188.42	2075.37	175.8	33435.09	9060.07	42495.16
JONES	M	391	020	000			8.00	0.46	8.46	4.9	129.92	43.60	173.52
		391	021	000			2.00	0.12	2.12	95.1	31.18	10.46	41.64
SUBTOTAL		391					10.00	0.58	10.58	100.0	161.10	54.06	215.16
TOTAL							10.00	0.58	10.58	100.0	161.10	54.06	215.16
LINN	J	391	021	000			24.01	4.69	28.70	100.0	415.39	118.48	533.87
TOTAL							24.01	4.69	28.70	100.0	415.39	118.48	533.87
MORTON	W	391	010	000			1.67	0.05	1.72	1.0	22.01	6.61	28.62
		391	021	000			3.33	0.10	3.43	99.0	41.81	12.56	54.37
SUBTOTAL		391					5.00	0.15	5.15	100.0	63.82	19.17	82.99
TOTAL							5.00	0.15	5.15	100.0	63.82	19.17	82.99
NICHOLS	J	391	001	000			67.02	14.71	81.73	100.0	1936.00	482.77	2418.77
TOTAL							67.02	14.71	81.73	100.0	1936.00	482.77	2418.77
PAVLAS	P	391	021				10.01	3.87	13.88	10.4	138.55	51.03	189.58
		391	021	000			30.01	18.78	48.79	89.6	377.13	160.81	537.94
SUBTOTAL		391					40.02	22.65	62.67	100.0	515.68	211.84	727.52
TOTAL							40.02	22.65	62.67	100.0	515.68	211.84	727.52
TIRRES	R	391	010	000			9.99	0.00	9.99	5.0	65.11	4.98	70.09
		391	020	000			175.01	4.05	179.06	89.7	1291.91	311.57	1603.48
		391	021	000			154.65	3.22	157.87	5.3	1129.13	255.80	1384.93
SUBTOTAL		391					339.65	7.27	346.92	100.0	2486.15	572.35	3058.50
TOTAL							339.65	7.27	346.92	100.0	2486.15	572.35	3058.50
WALDRON	S	391	010				53.68	6.02	59.70	36.8	837.55	240.35	1077.90
		391	010	000			100.34	10.75	111.09	68.4	1574.19	448.20	2022.39
		391	020				340.65	30.77	371.42	228.8	5151.93	1478.41	6630.34
		391	020	000			1228.00	141.48	1369.48	843.6	19387.24	5516.60	24903.84
		391	021				61.34	8.43	69.77	43.0	988.52	283.66	1272.18
		391	021	000			73.01	9.03	82.04	0.0	1160.63	330.63	1491.26
SUBTOTAL		391					1857.02	206.48	2063.50	220.6	29100.06	8297.85	37397.91
TOTAL							1857.02	206.48	2063.50	220.6	29100.06	8297.85	37397.91

Report Total $122,571.79

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy Arnold

Social Security Number —PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	021		02	00	059						
2	01	241	021		02	00	059						
3	01	249	021		02	00	059						
4	01	371	021		02	00	059						
5	02	241	010		00	20	059						
6	02	241	021		01	40	051						
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17													
18													

ENTERED
JUN 12 2001
TIME & EFFORT

ENTERED
MAY 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy Arnold

Supervisor's Signature James R. Turn

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Janice Buck

Month 04 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	250	001		02	00	058						
2	02	391	021		05	40	058						
3	02	250	010		00	20	058						
4	03	005	021		03	00	058						
5	03	005	010		02	00	058						
6	03	250	001		03	00	058						
7	04	257	021		02	00	058						
8	04	374	021		02	00	058						
9	04	340	021		03	20	058						
10	04	340	010		00	40	058						
11	05	257	021		02	00	058						
12	05	266	021		03	00	058						
13	05	005	021		02	40	058						
14	05	005	010		00	20	058						
15	06	301	003		08	00	058						
16													
17													
18													

ENTERED
JUL 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	005	021		01	40	058						
2	09	005	010		00	20	058						
3	09	257	021		02	00	058						
4	09	241	021		04	00	058						
5	10	238	021		04	00	058						
6	10	340	021		03	20	058						
7	10	340	010		00	40	058						
8	11	391	021		04	00	058						
9	11	005	021		03	40	058						
10	11	005	010		00	20	058						
11	12	238	021		04	00	058						
12	12	166	149		01	00	058						
13	12	301	002		03	00	058						
14	13	005	021		03	20	058						
15	13	005	010		00	40	058						
16	13	301	002		03	00	058						
17	13	257	021		01	00	058						
18													

ENTERED
JUL 0 6 2011
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number –PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	257	021		02	00	058						
2	16	0005	021		04	00	058						
3	16	2500	001		02	00	058						
4	17	257	021		02	00	058						
5	17	391	021		04	00	058						
6	17	374	021		02	00	058						
7	18	0005	021		04	20	058						
8	18	0005	010		00	40	058						
9	18	257	021		01	00	058						
10	18	250	001		02	00	058						
11	19	0005	021		04	20	058						
12	19	0005	010		01	40	058						
13	19	257	021		02	00	058						
14	20	0005	021		05	20	058						
15	20	0005	010		02	40	058						
16													
17													
18													

ENTERED
JUL 0 6 2004
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature J. Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 4 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	301	003		08	00	058						
2	24	301	003		08	00	058						
3	25	257	021		01	20	058						
4	25	340	021		03	00	058						
5	25	391	021		03	00	058						
6	25	340	010		00	40	058						
7	26	266	021		01	40	058						
8	26	257	010		01	40	058						
9	26	257	021		04	40	058						
10	27	257	021		06	20	058						
11	27	257	010		01	40	058						
12													
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ENTERED
JUL 0 9 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	241	021		02	00	058						
2	07	005	021		04	40	058						
3	07	005	010		01	20	058						
4	08	005	021		03	20	058						
5	08	005	010		00	40	058						
6	08	250	001		02	00	058						
7	08	266	021		02	00	058						
8	09	005	021		04	20	058						
9	09	005	010		00	40	058						
10	09	374	021		03	00	058						
11	10	266	021		03	00	058						
12	10	257	021		02	00	058						
13	10	391	021		02	20	058						
14	10	266	010		00	40	058						
15	11	266	021		02	00	058						
16	11	257	021		02	00	058						
17	11	238	010		00	20	058						
18	11	374	021		03	40	058						

ENTERED
JUL 12 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature J Nichols

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month: 05 Year: 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	021		03	00	058						
2	14	238	021		02	00	058						
3	14	250	001		02	40	058						
4	14	250	010		00	20	058						
5	15	257	021		03	00	058						
6	15	266	021		03	00	058			AUG 06 2001			
7	15	374	021		02	00	058			TIME & EFFORT			
8	16	257	021		03	00	058						
9	16	005	021		04	20	058						
10	16	005	010		00	40	058						
11	17	266	021		04	00	058						
12	17	391	021		02	00	058						
13	17	257	021		02	00	058						
14	18	257	021		03	00	058						
15	18	005	021		02	20	058						
16	18	005	010		00	40	058						
17	18	166	149		02	00	058						
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Janice Buck

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month: 0 5 Year: 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	246	021		02	00	058						
2	21	005	021		04	00	058						
3	21	391	021		02	00	058						
4	22	005	021		04	20	058						
5	22	005	010		01	40	058						
6	22	257	021		02	00	058						
7	23	250	001		03	00	058						
8	23	005	021		03	00	058						
9	23	238	021		02	00	058						
10	24	301	002		08	00	058						
11	25	301	002		08	00	058						
12													
13													
14													
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AUG 06 2001

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	257	021		02	00	058						
2	18	266	021		01	00	058						
3	18	005	021		04	20	058						
4	18	005	010		00	40	058						
5	19	257	021		02	00	058						
6	19	005	021		03	00	058						
7	19	005	010		00	40	058						
8	19	250	001		02	20	058						
9	20	257	021		02	00	058						
10	20	005	021		05	00	058						
11	20	005	010		01	00	058						
12	21	238	021		03	00	058						
13	21	250	001		02	20	058						
14	21	005	021		02	00	058						
15	21	005	010		00	40	058						
16	22	250	001		03	20	058						
17	22	391	021		04	00	058						
18	22	340	010		00	40	058						

ENTERED
AUG 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	3010	004		08	00	058						
2	26	257	021		02	00	058						
3	26	391	021		04	00	058						
4	26	005	021		01	20	058						
5	26	005	010		00	40	058						
6	27	005	010		01	40	058						
7	27	2500	001		02	20	058						
8	27	257	021		02	00	058						
9	27	3401	021		02	00	058						
10	28	3401	010		01	00	058						
11	28	257	021		02	00	058						
12	28	266	021		03	00	058						
13	28	2500	001		02	00	058						
14	29	238	021		03	00	058						
15	29	391	021		03	00	058						
16	29	257	021		01	20	058						
17	29	3401	010		00	40	058						
18													

ENTERED
AUG 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	257	021		02	00	058						
2	09	266	021		02	00	058						
3	09	005	021		03	20	058						
4	09	005	010		00	40	058						
5	10	257	021		02	00	058						
6	10	238	021		02	00	058						
7	10	005	021		02	20	058						
8	10	005	010		01	40	058						
9	11	005	021		05	20	058						
10	11	257	021		02	00	058						
11	11	005	010		00	40	058						
12	12	257	021		03	00	058						
13	12	391	021		02	00	058						
14	12	340	021		02	20	058						
15	12	340	010		00	40	058						
16	13	257	021		04	00	058						
17	13	005	021		03	20	058						
18	13	005	010		00	40	058						

ENTERED
SEP 24 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature J. Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Janice Buck

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month: 07 Year: 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	257	021		02	00	058						
2	30	266	021		02	00	058						
3	30	D05	021		03	20	058						
4	30	005	010		00	40	058						
5	31	257	021		02	00	058						
6	31	391	021		02	00	058						
7	31	238	021		02	00	058						
8	31	340	021		01	20	058						
9	31	340	010		00	40	058						
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16													
17													
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ENTERED
OCT 15 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 8 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	257	021		02	00	058						
2	20	005	021		02	20	058						
3	20	005	010		00	40	058						
4	20	391	021		03	00	058						
5	21	257	021		02	00	058						
6	21	241	021		03	00	058						
7	21	340	021		02	20	058						
8	21	340	010		00	40	058						
9	22	257	021		02	00	058						
10	22	250	001		04	00	058						
11	22	005	021		01	20	058						
12	22	005	010		00	40	058						
13	23	391	021		04	00	058						
14	23	266	021		03	20	058						
15	23	340	021		00	40	058						
16	24	257	021		02	00	058						
17	24	391	021		05	20	058						
18	24	391	010		00	40	058						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 9 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	301	009		08	00	058						
2	04	301	003		08	00	058						
3	05	257	021		02	00	058						
4	05	250	021		03	00	058						
5	05	005	021		02	40	058						
6	05	005	010		00	20	058						
7	06	301	002		03	00	058						
8	06	257	021		02	00	058						
9	06	250	001		03	00	058						
10	07	257	021		01	00	058						
11	07	266	021		01	00	058						
12	07	391	021		02	00	058						
13	07	374	021		02	00	058						
14	07	005	010		01	20	058						
15	07	005	021		00	40	058						
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature [redacted]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	257	021		02	00	058						
2	17	241	021		03	00	058						
3	17	374	021		02	40	058						
4	17	241	010		00	20	058						
5	18	340	021		03	00	058						
6	18	340	010		00	40	058						
7	18	391	021		04	20	058						
8	19	257	021		02	00	058						
9	19	250	001		02	00	058						
10	19	005	021		03	20	058						
11	19	005	010		00	40	058						
12	20	005	021		03	40	058						
13	20	005	010		02	20	058						
14	20	340	021		02	00	058						
15	21	005	021		02	20	058						
16	21	005	010		00	40	058						
17	21	257	021		02	00	058						
18	21	238	021		02	00	058						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

ENTERED JAN 16 2001

TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	02	3911	021		04	00							
2	02	3833	021		04	00							
3	03	3833	021		08	00							
4	04	3833	021		06	00							
5	05	3833	021		07	00							
6	05	3833	010		02	00							
7	06	3833	021		07	00							
8	06	3833	010		02	00							
9													
10													
11													
12													
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14													
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17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret Supervisor's Signature J.K

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

ENTERED JAN - 6 2001

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	39	1	021	04	00				TIME & EFFORT			
2	09	383	021		04	00							
3	10	383	021		08	00							
4	11	383	021		08	00							
5	12	383	021		04	00							
6	12	3B1	004		04	00							
7	13	383	021		08	00							
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature X SK

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	3913	021		04	00							
2	16	3833	021		04	00							
3	17	3833	021		07	00							
4	17	3010	002		01	00							
5	18	3833	021		07	00							
6	18	3010	002		01	00							
7	19	3833	021		06	00							
8	19	3010	002		02	00							
9	20	3833	021		06	00							
10	20	3010	002		02	00							
11													
12													
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15													
16													
17													
18													

ENTERED
JAN 03 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

ENTERED JAN - 6 (illegible)

TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	23	391	021		04	00							
2	23	383	021		05	00							
3	24	383	021		08	00							
4	25	383	021		08	00							
5	26	301	002		07	00							
6	27	383	021		08	00							
7													
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14													
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16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

ENTERED
JAN - 6 2001

Month 10 Year 00

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Time & Effort	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30391	021			04	00							
2	30383	021			04	00							
3	31383	021			08	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature S.M.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2/5

Employee Xev Cadaret

Month 11 Year 00

Social Security Number -PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	021		04	00							
2	06	383	021		04	00							
3	07	383	021		08	00							
4	08	383	021		04	00				ENTERED			
5	09	383	021		04	00				FEB 0 2 2001			
6	10	3301	009		08	00				TIME & EFFORT			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature X Cadaret

Supervisor's Signature S.K

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 06

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	3910	021		04	00							
2	13	8833	021		04	00							
3	14	3833	021		08	00							
4	15	3833	021		06	00							
5	16	3833	021		08	00				ENTERED			
6	17	3833	021		06	00				FEB 02 2001			
7	17	3010	0002		02	00				TIME & EFFORT			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	3 9 1	0 2 1		0 4	0 0							
2	20	3 8 3	0 2 1		0 4	0 0							
3	21	3 8 3	0 2 1		0 8	0 0							
4	22	3 8 3	0 2 1		0 8	0 0							
5	23	3 0 1	0 0 9		0 6	0 0							
6	24	3 0 1	0 0 9		0 5	0 0							
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ENTERED
FEB 01 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month: 11 Year: 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	341	021		04	00							
2	27	383	021		04	00							
3	28	383	021		08	00							
4	29	383	021		08	00							
5	30	383	021		08	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2/5

Employee Kear Cadaret

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	3911	021		04	00							
2	04	3833	021		04	00							
3	05	3833	021		08	00							
4	06	3833	021		08	00							
5	07	3833	021		08	00							
6	08	3011	003		08	00							
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ENTERED
FEB 23 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K- Cadaret

Supervisor's Signature JK

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3/5

Employee Kay Cadance

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	38	3 010		06	00							
2	10	38	3 021		03	00							
3	11	38	3 021		08	00							
4	12	30	1 002		08	00							
5	13	30	1 002		08	00							
6	15	39	1 021		04	00							
7	15	38	3 021		04	00							
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ENTERED
FEB 2 3 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadance

Supervisor's Signature J.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Month 12 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	021		04	00							
2	18	383	021		04	00							
3	19	383	021		08	00							
4	20	383	021		08	00							
5	21	301	002		08	00							
6	22	383	021		08	00							
7													
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ENTERED
FEB 23 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1 of 5

Employee Kev Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	009		08	00							
2	02	391	021		04	00							
3	02	383	021		04	00							
4	03	383	021		04	00							
5	04	383	021		08	00							
6	05	383	021		08	00							
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	021		04	00							
2	08	383	021		04	00							
3	09	383	021		08	00							
4	10	383	021		08	00							
5	11	383	021		04	00							
6	11	301	003		04	00							
7	12	383	021		08	00							
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12													
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature Shari K

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	301	009		08	00							
2	16	391	021		04	00							
3	16	383	021		04	00							
4	17	383	021		08	00							
5	18	383	021		08	00							
6	19	383	021		06	00							
7	19	301	002		02	00							
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature S.L.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4/5

Employee Kay Cadance

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	39183	021		04	00							
2	22	38321	021		05	00							
3	23	38321	021		08	00							
4	24	38321	021		08	00							
5	25	38321	021		08	00							
6	26	38321	021		07	00							
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadance

Supervisor's Signature S.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

Month 01 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	39	10	21	04	00							
2	29	38	30	21	04	00							
3	30	38	30	21	08	00							
4	31	38	30	21	08	00							
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Ken Cadaret

Supervisor's Signature S. King

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	021		04	00							
2	05	383	021		04	00							
3	06	393	021		08	00							
4	07	383	021		08	00							
5	08	383	021		06	00							
6	09	393	021		10	00							
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MAY 1 8 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Ken Cadaret

Supervisor's Signature S.H.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadanet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	12	391	021		04	00							
2	12	383	021		02	00							
3	12	301	004		01	00							
4	13	383	021		08	00							
5	14	393	021		08	00							
6	15	393	021		08	00							
7	16	383	021		09	00							
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MAY 1 8 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Month 02 Year 01

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	19	30	1	009	08	00							
2	20	39	1	021	04	00							
3	20	38	3	021	04	00							
4	21	38	3	021	08	00							
5	22	38	3	021	08	00							
6	23	38	3	021	07	20							
7	23	30	1	002	00	40							
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature S.K

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5/5

Employee Kev Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	021		04	00							
2	26	383	021		04	00							
3	27	383	021		08	00							
4	28	383	021		08	00							
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MAY 24 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J.S.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 02

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	021		04	00							
2	05	383	021		04	00							
3	06	383	021		08	00							
4	07	383	021		04	00							
5	08	383	021		09	00							
6	09	383	021		06	00							
7	10	383	021		02	00							
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ENTERED
JUN 25 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	39i	021		04	00							
2	12	383	021		04	00							
3	13	383	021		08	00							
4	14	383	021		12	00							
5	15	301	004		04	00							
6	16	301	002		08	00							
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ENTERED
JUN 2 2 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K-Cadaret

Supervisor's Signature Debra D. Anderson

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	391	021		04	00							
2	19	383	021		04	20							
3	20	383	021		08	20							
4	21	383	021		08	20							
5	22	383	021		03	00							
6	22	301	0004		05	00							
7	23	383	021		07	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Keri Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	301	004		03	00							
2	26	383	021		01	00							
3	26	391	021		04	00							
4	27	383	021		08	00							
5	28	383	021		08	00							
6	29	383	021		08	00							
7	30	301	004		06	00							
8	30	383	021		02	00							
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ENTERED
JUN 21 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K-Cadaret

Supervisor's Signature SK

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Kent Cadaret

Month 04 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	021		04	00							
2	02	383	021		04	00							
3	03	383	021		08	00							
4	04	383	021		08	00							
5	05	301	603		04	00							
6	06	383	021		08	00							
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ENTERED
JUL 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature S.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	021		04	00							
2	09	383	021		04	00							
3	10	383	021		08	00							
4	11	383	021		08	00							
5	12	383	021		08	00							
6	13	383	021		08	00							
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ENTERED
JUL 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J.S.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadaret

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	021		04	00							
2	16	383	021		04	00							
3	17	383	021		08	00							
4	19	383	021		08	00							
5	19	383	021		08	00							
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ENTERED
JUL 09 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Kay Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	021		04	00							
2	23	383	021		04	00							
3	24	383	021		08	00							
4	25	383	021		08	00							
5	26	383	021		06	00							
6	27	383	021		07	00							
7	27	301	000		01	00							
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ENTERED
JUL 09 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Kevin Cadaret

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	391	021		04	00							
2	30	383	021		04	00							
3													
4													
5													
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18													

ENTERED
JUL 0 9 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	021		04	00							
2	08	363	021		04	00							
3	08	383	021		10	00							
4	09	383	021		09	00							
5	10	363	021		08	00							
6	11	363	021		03	00							
7	11	301	002		02	00							
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ENTERED
JUL 12 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature SA

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Kari Caldwell

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	3919	021		04	00							
2	14	3833	021		04	00							
3	15	3833	021		10	00							
4	16	3833	021		08	00							
5	17	3833	021		07	40							
6	18	3833	021		06	20							
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ENTERED
JUL 30 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	383	021		06	00							
2	21	391	021		04	00							
3	21	383	021		04	00							
4	22	383	021		08	00							
5	23	383	021		03	00							
6	24	383	021		08	00							
7	25	383	021		07	00							
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ENTERED
JUL 30 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	301	009		08	00							
2	29	383	021		08	00							
3	30	383	021		08	00							
4	31	39C	021		04	00							
5	31	383	021		04	00							
6													
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ENTERED
JUL 30 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2/5

Employee Kay Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	021		04	00							
2	04	383	021		04	00							
3	05	383	021		08	00							
4	06	383	021		08	00							
5	07	383	021		06	00							
6	09	383	010		10	00							
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ENTERED
SEP 17 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature SK

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3/5

Employee Kevin Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	383	021		8	00							
2	11	383	021		8	00							
3	12	383	021		8	00							
4	13	383	021		5	00							
5	13	383	010		9	00							
6	14	383	010		2	00							
7	14	383	021		7	00							
8	15	383	021		3	00							
9	15	391	021		4	00							
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11													
12										ENTERED			
13										SEP 17 2001			
14										TIME & EFFORT			
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17													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Kevin Cadaret

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Kev Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	021		04	00							
2	18	383	021		04	00							
3	19	383	021		06	20							
4	19	301	008		01	40							
5	20	383	021		08	00							
6	21	383	021		08	00							
7	22	383	021		06	00							
8	22	301	003		02	00							
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ENTERED
SEP 17 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J. K

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Kev Cadaret

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Month 0 6 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	391	021		04	00							
2	25	383	021		03	00							
3	25	301	008		01	00							
4	26	301	008		08	00							
5	27	301	008		03	20							
6	27	301	002		04	40							
7	28	301	002		08	00							
8	29	383	021		08	00							
9													
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ENTERED
SEP 17 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadaret

Month 07 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	3 9 3	0 2 1		0	8 0							
2	17	3 9 3	0 2 1		0	8 0							
3	18	3 9 3	0 2 1		0	8 0							
4	19	3 9 1	0 2 1		0	4 0							
5	19	3 9 3	0 2 1		0	4 0							
6	20	3 9 3	0 2 1		0	8 0							
7													
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ENTERED
OCT 15 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Kay Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	021		04	00							
2	23	383	021		04	00							
3	24	383	021		09	00				ENTERED			
4	25	383	021		08	00				OCT 1 0 2001			
5	26	383	021		06	00				TIME & EFFORT			
6	27	383	021		07	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	301	003		01	40							
2	30	391	021		04	00							
3	30	383	021		02	20							
4	31	383	021		08	00							
5													
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ENTERED
OCT 1 5 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature S.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	3911	021		04	00							
2	06	3833	021		04	00							
3	07	3833	021		08	00							
4	08	3833	021		08	00							
5	09	3833	021		08	00							
6	10	3833	021		08	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

OOH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3/5

Employee Kai Cadaret

Month 08 Year 21

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	3391	021		04	00							
2	13	3833	021		04	0							
3	14	3833	021		08	00							
4	15	3833	021		08	00							
5	16	3833	021		04	20							
6	16	3833	010		04	40							
7	17	3833	021		08	00							
8	17	3833	010		03	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature JK

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4/5

Employee Kevin Cadaret

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month: 08 Year: 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	021		04	00							
2	20	383	021		04	00							
3	21	383	021		08	00							
4	22	383	021		08	00							
5	23	383	021		08	00							
6	24	383	021		07	00							
7	24	301	008		01	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5/5

Employee Kev Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	021		04	00							
2	27	383	021		04	00							
3	28	383	021		08	00							
4	29	383	021		08	00							
5	30	383	021		07	00							
6	30	301	008		01	00							
7	31	383	021		07	00							
8	31	301	008		01	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Ken Cadaret

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month: 09 Year: 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	021		04	00							
2	10	383	021		03	40							
3	11	383	021		02	00							
4	11	301	014		06	00							
5	12	301	014		08	00							
6	13	383	021		08	00							
7	14	383	021		08	20							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature: K. Cadaret

Supervisor's Signature: D.K.

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Ken Calvert

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	39103	021		04	00							
2	17	38303	021		04	00							
3	18	38303	021		04	00							
4	19	38303	021		04	00							
5	20	38303	021		04	00							
6	21	38303	021		04	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Calvert

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	021		04	00							
2	24	383	021		03	00							
3	25	383	021		07	00							
4	26	383	021		07	00							
5	27	383	010		07	00							
6	27	383	021		06	00							
7	28	383	010		06	00							
8	28	383	021		08	00							
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature J.K.

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL 002

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	331	010	001	04	00	061						
2	26	331	431	002	05	00	061						
3	27	391	010	001	04	00	058						
4	27	391	426	001	03	20	058	004	001				
5	27	391	441	001	01	40	058						
6	28	331	431	001	04	00	001						
7	28	328	431	001	04	00	001						
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ENTERED
MAY 24 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL 002

Month 10 Year 00

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	441	001	01	20	058						
2	16	391	431	001	06	40	058						
3	17	391	010	001	02	00	058						
4	17	391	431	001	04	00	058			ENTERED			
5	17	391	411	001	03	00	058	601		DEC 18 2000			
6	18	391	010	001	01	20	058			TIME & EFFORT			
7	18	391	426	001	07	40	058						
8	19	391	010	001	02	00	058						
9	19	391	426	001	04	00	058						
10	19	391	431	001	02	00	058						
11	20	301	008		02	00	001						
12	20	301	002		04	00	601						
13													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee KAREN K. CORNELL 002

Month 10 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	301	003		02	20	001						
2	23	331	431	001	05	40	001						
3	24	328	411	001	08	00	001						
4	25	288	010	001	00	40	001						
5	25	288	428	001	04	20	001	002	002	17			
6	25	331	431	001	03	00	001						
7	26	328	411	001	08	00	001	001	001				
8	27	328	431	001	03	00	001						
9	27	391	426	001	02	00	058						
10	27	301	003		03	00	001						
11													
12													
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ENTERED
DEC 1 8 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee KAREN K. CORNELL 001

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	328	412	001	01	40	001	003	001				
2	17	328	431	001	06	20	001						
3	18	331	010	001	02	20	001						
4	18	331	441	002	05	40	001						
5	19	391	010	001	02	20	058						
6	19	391	431	001	05	40	058						
7	20	391	010	001	00	40	058						
8	20	391	411	001	03	00	058						
9	20	391	431	001	04	20	058						
10	21	391	010	001	02	20	058						
11	21	391	411	001	03	00	058						
12	21	391	431	001	02	40	058						
13													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	331	441	001	04	00	001						
2	24	391	010	001	02	20	058						
3	24	391	426	001	03	00	058						
4	25	328	411	001	04	00	001	001	001				
5	25	328	431	001	01	00	001						
6	25	328	010	001	02	20	021						
7	25	328	426	001	01	40	021						
8	26	331	426	002	05	40	001						
9	26	331	010	001	02	20	001						
10	27	328	412	001	01	20	001	002	001				
11	27	328	426	001	02	40	001						
12	27	331	431	001	04	00	001						
13	28	288	441	001	07	00	001						
14													
15													
16													
17													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bradley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	331	441	001	01	00	001						
2	06	328	431	001	02	20	001						
3	06	331	427	001	02	00	001						
4	06	331	431	001	02	40	001						
5	07	328	411	001	08	00	001	001					
6	08	328	412	001	02	20	001	002	002				
7	09	301	004		03	00	001						
8	09	391	425	001	01	00	058						
9	09	328	431	001	01	60	001						
10	09	331	431	001	03	00	001						
11	10	301	009		08	00	001						
12													
13													
14													
15													
16													
17													
18													

ENTERED
FEB 02 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL 002

Month 12 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	331	001	002	01	00	001						
2	04	331	441	001	03	00	001						
3	04	331	427	001	02	00	001						
4	04	331	431	001	02	00	001						
5	05	391	010	001	63	20	058						
6	05	391	411	001	02	00	058	001	001				
7	05	391	427	001	02	40	058						
8	06	391	010	001	01	00	058						
9	06	391	411	001	07	00	058	001	001				
10	07	391	010	001	00	40	058						
11	07	391	411	001	07	20	05F	001	001				
12	08	391	010	001	00	40	058						
13	08	391	411	001	06	00	058	001	001				
14	08	391	010	001	02	00	011						
15													
16													
17													
18													

ENTERED
MAR 05 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL 002

Month 01 Year 01

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	331	427	001	01	40	001						
2	08	331	441	001	01	00	001						
3	08	331	431	001	03	2	001						
4	08	328	431	001	02	40	001						
5	09	391	010	001	04	00	058						
6	09	391	427	001	05	00	058						
7	10	328	431	001	01	40	001						
8	10	328	412	001	01	40	001	002	061				
9	10	331	431	001	04	40	001						
10	11	328	431	001	02	00	001						
11	11	331	010	001	02	20	001						
12	11	331	427	002	02	00	001						
13	11	331	426	001	03	00	001						
14	11	331	431	001	01	40	001						
15	12	328	411	001	06	00	001	001	001				
16	13	288	427	001	05	20	001						
17	13	288	428	001	01	00	001	007	001	17			
18													

ENTERED APR 04 2001 TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL OCR

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 0 1 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	301	009		08	00	001						
2	16	301	008		04	00	001						
3	16	288	010	001	01	00	001						
4	16	288	441	001	03	00	001						
5	17	331	441	001	07	40	001						
6	17	3[illegible]1	008		00	20	001						
7	18	391	441	001	06	00	058						
8	18	331	441	001	02	00	001						
9	19	331	441	001	08	00	001						
10													
11													
12													
13													
14													
15													
16													
17													
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ENTERED
MAR 2 9 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee KAREN K CORNELL PDS

Month 01 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	331	010	001	03	00	200						
2	22	331	426	001	02	00	200	012	001				
3	22	331	441	001	01	40	200						
4	22	331	010	001	03	00	011						
5	23	3288	010	001	01	20	011						
6	23	3288	426	001	01	20	011	004	001				
7	23	3288	010	001	00	40	001						
8	23	3288	426	001	01	40	001	007	001				
9	23	331	431	001	03	00	001						
10	24	3018	008		01	20	001						
11	24	3288	431	001	02	00	001						
12	24	3911	431	001	03	00	058						
13	25	3288	411	001	08	00	001	001	001				
14	26	3288	411	001	08	00	001	001	001				
15													
16													
17													
18													

ENTERED MAR 29 2004 TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley by DS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Karen K. Cornell 002

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	301	009		08	00	001						
2	20	391	010	001	02	20	058						
3	20	391	427	002	02	00	058						
4	20	391	426	001	02	00	058	006	001				
5	20	391	431	001	01	40	058						
6	21	391	411	001	04	00	058	001	001				
7	21	391	010	001	00	40	058						
8	21	391	426	001	03	20	058	006	001				
9	22	391	411	001	08	00	058	002	002				
10	23	391	412	001	01	20	058	001	001				
11	23	391	426	001	02	40	058	002	001				
12	23	391	431	001	01	20	058						
13	23	391	010	001	02	40	058						
14													
15													
16													
17													
18													

ENTERED
MAY 24 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL 002

Month 06 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	331	010	001	06	00	200						
2	11	331	427	002	03	00	200						
3	12	391	010	001	02	00	058						
4	12	391	411	001	03	00	058	001	001				
5	12	391	431	001	03	20	058						
6	13	391	010	001	01	00	058						
7	13	391	411	001	03	00	058	001	001				
8	13	391	412	001	00	20	058	001	001				
9	13	391	431	001	04	40	058						
10	14	391	010	001	01	00	058						
11	14	391	411	001	03	00	058	001	001				
12	14	391	412	001	01	40	058	002	002	ENTERED			
13	14	391	427	001	01	40	058			5-21-2001			
14	14	391	431	001	02	00	058			TIME & EFFORT			
15	15	391	431	001	01	00	058						
16	15	391	010	001	02	00	058						
17	15	391	441	001	00	40	058						
18	15	301	008		00	40	091						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bailey by [illegible]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	010	001	02	40	058						
2	16	391	426	001	01	20	058						
3	16	391	431	001	04	00	058						
4	17	391	411	001	03	40	058						
5	17	391	431	001	03	40	058						
6	17	391	010	001	01	00	058						
7	18	391	010	001	00	40	058						
8	18	391	411	001	03	00	058						
9	18	391	412	002	01	20	058						
10	18	391	431	001	03	00	058						
11	19	391	010	001	02	40	058						
12	19	391	411	001	03	20	058						
13	19	391	431	001	03	00	058						
14	20	331	010	001	02	40	067						ENTERED
15	21	331	010	001	02	20	067						JUL 10 2001
16	21	331	428	001	01	00	067	010	001	17			TIME & EFFORT
17	21	331	427	001	01	40	067						
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley for P Stephen

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL CO2

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	010	001	02	00	058						
2	07	391	010	001	00	40	058						
3	07	391	411	001	03	00	058	001	001				
4	07	391	431	001	03	40	058						
5	07	391	426	001	01	00	058						
6	08	391	010	001	02	40	058						
7	08	391	411	001	03	00	058						
8	08	391	431	001	02	00	058						
9	08	391	426	001	02	20	058						
10	09	331	010	001	03	00	001						
11	09	331	441	001	01	00	001						
12	10	331	010	001	00	40	001						
13	10	331	427	001	07	40	001						
14	10	331	010	001	03	00	011						
15	11	288	441	001	02	00	001						
16	11	328	431	001	02	00	001						
17	11	331	431	001	04	00	001						
18													

ENTERED
JUL 12 2001
TIME & EFFORT

I certify that these statements are correct and that both for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley by [illegible]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Karen K. Cornell 002

Month 07 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	328	411	001	08	00	001						
2	24	328	431	001	04	00	001						
3	24	331	431	001	04	00	001						
4	25	391	010	001	04	00	058						
5	25	391	441	001	04	00	058						
6	26	301	004		08	00	001						
7	27	301	004		08	00	001						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
OCT - 2 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Badgett by Wanda Zavala

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	391	010	001	02	20	058						
2	12	391	431	001	05	40	058						
3	13	391	010	001	01	00	058						
4	13	391	411	001	07	00	058	001	001				
5	14	391	010	001	00	20	058						
6	14	391	411	001	03	20	058	001	001				
7	14	391	426	001	01	00	058						
8	14	391	431	001	04	20	058						
9	15	391	010	001	00	40	058						
10	15	391	411	001	07	20	058	002	002				
11	15	391	431	001	01	00	058						
12	16	391	431	001	03	00	058						
13	16	391	426	001	02	40	058						
14	16	391	010	001	02	20	058						
15													
16													
17													
18													

ENTERED
JUN 2 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee KAREN K. CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	301	008		08	00	001						
2	27	328	4110	001	08	00	001						
3	28	328	4310	001	02	00	001						
4	28	331	0100	001	04	00	001						
5	28	331	4270	001	02	00	001						
6	29	331	0100	001	00	20	001						
7	29	288	4270	001	01	00	001	002	001				
8	29	391	4310	001	04	00	058						
9	29	331	4310	001	03	40	001						
10	30	331	4310	001	07	00	001						
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee KAREN K. CORNELL 002

Month 02 Year 01

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	331	010	001	02	00	061						
2	12	331	431	001	03	20	061						
3	12	331	427	062	01	40	061						
4	12	331	010	001	02	00	011						
5	13	331	441	001	01	00	001						
6	13	331	431	001	02	40	001						
7	13	391	010	001	02	20	058						
8	13	391	431	001	03	00	058						
9	14	391	411	001	04	00	058	001	001				
10	14	391	431	001	03	00	058						
11	14	391	426	001	01	00	058						
12	14	391	010	001	00	40	058						
13	15	391	431	001	06	20	058	002	002				
14	15	391	010	001	03	40	058						
15	15	391	431	001	02	00	058						
16	16	391	431	001	02	00	058						
17	16	391	426	001	01	20	058						
18	16	391	010	001	03	00	011						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2 of 2

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	289	021		02	00							
2	09	336	021		01	40							
3	09	287	021		01	20							
4	09	284	021		01	00							
5	09	385	021		01	00							
6	09	233	021		03	00							
7	11	238	021		02	00							
8	11	385	021		02	00							
9	11	388	021		01	00							
10	11	284	021		03	00							
11	11	289	021		02	00							
12	12	289	021		03	00							
13	12	287	021		01	00							
14	12	385	021		02	00							
15	12	238	021		02	00							
16	12	284	021		02	00							
17	13	289	021		03	00							
18	13	391	021		00	46							

ENTERED
DEC 19 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory Morley MS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4 of 5

Employee Sonja Joyce Fouquet

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	289	021		0	00							
2	16	238	021		0	100							
3	16	385	021		0	200							
4	16	391	021		0	100							
5	17	301	021		0	800					ENTERED		
6	18	301	021		0	800					DEC 19 2000		
7	19	289	021		0	400					TIME & EFFORT		
8	19	238	021		0	200							
9	19	385	021		0	200							
10	20	330	021		0	100							
11	20	238	021		0	100							
12	20	349	021		0	100							
13	20	377	021		0	100							
14	20	383	021		0	100							
15	20	289	021		0	100							
16	20	287	021		0	200							
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fouquet

Supervisor's Signature Gregory A Morley OK per SS

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 6

Employee Sonja Joyce Fougeat

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	2849	021		02	00							
2	30	3855	021		01	00							
3	30	2388	021		01	00							
4	30	3941	021		01	00							
5	30	3717	021		01	00							
6	30	3499	021		01	00							
7	30	3699	021		01	00							
8	31	2899	021		08	00							
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

ENTERED
DEC 19 2000
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joyce Fougeat

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee: **SONJA J FOUQUET**

Week 1

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 2000

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location Code	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	01	289	021	000	03	00							
2	01	284	021	000	02	00							
3	01	385	021	000	03	00							
4	01	391	021	000	01	00							
5	02	289	021	000	06	20							
6	03	289	021	000	04	00							
7	03	238	021	000	02	00							
8	03	385	021	000	02	00							
9	03	233	021	000	00	40							
10													
11													
12													
13													
14													
15													
16													
17													
18													

MAR 02 2001

FINALED

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Jaye Fouquet

Supervisor's Signature Gregory A Morley

FMS

ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee: **SONJA J FOUQUET**

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Week 2

Month 11 Year 2000

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location Code	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	06	289	021	000	04	00							
2	06	330	021	000	01	00							
3	06	238	021	000	01	00							
4	06	385	021	000	01	00							
5	06	287	021	000	01	00							
6	07	289	021	000	06	00							
7	07	383	021	000	01	00							
8	07	284	021	000	01	00							
9	08	301	002	000	02	00							
10	08	383	021	000	01	00							
11	08	391	021	000	01	00							
12	08	385	021	000	02	00							
13	08	238	021	000	02	00							
14	09	369	021	000	03	20							
15	09	385	021	000	03	00							
16	09	284	021	000	01	00							
17	09	301	002	000	00	40							
18	10	301	009	000	08	00							

MAR 02 2001

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Jayne Fouquet

Supervisor's Signature Gregory A Mobley

FMS

ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

REVISED
17-Nov-00 3:25:24 PM

Employee: **SONJA J FOUQUET**

Week 3

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 2000

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location Code	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	13	238	021	0000	2	00							
2	13	284	021	0000	1	00							
3	13	330	021	0000	1	00							
4	13	388	021	0000	4	00							
5	14	284	021	0000	1	00							
6	14	289	021	0000	3	00							
7	14	385	021	0000	2	00							
8	14	388	021	0000	1	00							
9	14	391	021	0000	1	00							
10	15	289	021	0000	7	20							
11	15	301	002	0000	0	40							
12	16	284	021	0000	3	00							
13	16	289	021	0000	4	00							
14	16	233	021	0000	1	00							
15	17	383	021	0000	0	40							
16	17	233	021	0000	1	00							
17	17	289	021	0000	6	20							
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Joye Fouquet

Supervisor's Signature Gregory A Morley

FMS

ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee: **SONJA J FOUQUET**

Week 4

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 2000

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location Code	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	383	021	000	01	00							
2	20	377	021	000	01	00							
3	20	284	021	000	02	00							
4	20	378	021	000	00	20							
5	20	391	021	000	00	40							
6	20	289	021	000	03	00							
7	21	301	002	000	01	00							
8	21	378	021	000	02	00							
9	21	238	021	000	01	00							
10	21	349	021	000	01	00							
11	21	289	021	000	03	00							
12	22	391	021	000	04	00							
13	22	378	021	000	01	00							
14	22	289	021	000	03	00							
15	23	301	009	000	08	00							
16	24	301	009	000	08	00							
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Jaya Fouquet

Supervisor's Signature Gregory A Morley

CK
MS

FMS
ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee: **SONJA J FOUQUET**

Week 1

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 2000

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location Code	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	383	021	000	04	00							
2	01	391	021	000	04	00							
3													
4													
5													
6													
7													
8													
9													
10													
11													
12											ENTERED		
13											FEB 2 5 2001		
14											TIME & EFFORT		
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Jean Fouquet

Supervisor's Signature Gregory A Morley

CK 1115

FMS

ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

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11-Dec-00 4:26:04 PM

Employee: **SONJA J FOUQUET**

Week 2

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month 12 | Year 2000

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location Code	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	04	301	003	000	08	00							
2	05	349	021	000	03	00							
3	05	378	021	000	01	00							
4	05	385	021	000	01	00							
5	05	391	021	000	03	00							
6	06	233	021	000	01	00							
7	06	238	021	000	01	00							
8	06	284	021	000	01	00							
9	06	289	021	000	04	00							
10	06	383	021	000	01	00							
11	07	233	021	000	04	00							
12	08	238	021	000	04	00							
13	08	289	021	000	08	00							
14													
15													
16													
17													
18													

MAR 07 2001

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature _____

FMS
ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee: **SONJA J FOUQUET**

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Week 4

Month 12 Year 2000

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location Code	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	385	021	000	04	00							
2	18	289	021	000	04	00							
3	19	284	021	000	01	00							
4	19	385	021	000	02	00							
5	19	391	021	000	01	00							
6	19	349	021	000	02	00							
7	19	289	021	000	02	00							
8	20	287	021	000	01	00							
9	20	284	021	000	01	00				MAR 07 2001			
10	20	385	021	000	01	00							
11	20	238	021	000	02	00							
12	20	391	021	000	01	00							
13	20	289	021	000	02	00							
14	21	378	021	000	01	00							
15	21	385	021	000	01	00							
16	21	377	021	000	01	00							
17	21	289	021	000	05	00							
18	22	289	021	000	08	00							

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

FMS

ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee: **SONJA J FOUQUET**

Week 5

Month 12 Year 2000

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date		Program Code			Activity Code			Task Code			Time Hours		Time Minutes		Location Code			Unit Out			Number Sessions			Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	2	5	3	0	1	0	0	9	0	0	0	0	8	0	0												
2	2	6	3	0	1	0	0	2	0	0	0	0	8	0	0												
3	2	7	3	3	0	0	2	1	0	0	0	0	1	0	0												
4	2	7	2	8	7	0	2	1	0	0	0	0	1	0	0												
5	2	7	2	8	9	0	2	1	0	0	0	0	2	2	0												
6	2	7	3	7	7	0	2	1	0	0	0	0	1	0	0												
7	2	7	3	8	3	0	2	1	0	0	0	0	1	0	0												
8	2	7	3	0	1	0	0	2	0	0	0	0	1	4	0												
9	2	8	2	3	8	0	2	1	0	0	0	0	7	0	0												
10	2	8	3	9	1	0	2	1	0	0	0	0	1	0	0												
11	2	9	2	8	9	0	2	1	0	0	0	0	3	0	0									MAR 07 2001			
12	2	9	2	3	8	0	2	1	0	0	0	0	1	0	0												
13	2	9	2	3	3	0	2	1	0	0	0	0	1	0	0												
14	2	9	2	8	4	0	2	1	0	0	0	0	1	0	0												
15	2	9	3	7	7	0	2	1	0	0	0	0	1	0	0												
16	2	9	3	8	5	0	2	1	0	0	0	0	1	0	0												
17																											
18																											

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Sonja Jaye Fouquet

Supervisor's Signature Gregory A Morley

FMS

ODH form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Trudy L. Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

ENTERED
FEB 0 5 2001
TIME & EFFORT

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Other	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	231	010		01	20	058						
2	13	231	021		02	20	058						
3	13	266	020		02	20	058						
4	13	231	020		02	00	058						
5	14	318	010		01	20	058						
6	14	318	020		03	00	058						
7	14	231	020		02	00	058						
8	14	231	021		02	40	018						
9	15	231	020		02	00	018						
10	15	231	021		04	40	018						
11	15	318	020		01	20	618						
12	16	661	010		03	20	018						
13	16	391	010		02	00	058						
14	16	391	020		01	00	058						
15	16	661	020		03	40	058						
16	17	231	021		05	40	018						
17	17	231	010		00	20	018						
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee TRUDY L. FROST

Month 12 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	23 1	010		02	00	058						
2	18	23 1	021		02	00	058						
3	18	266	020		03	00	058				ENTER		
4	19	318	010		02	00	058				MAR 0 8 200		
5	19	318	020		05	40	058						
6	19	231	020		01	20	018				TIME & EFFOR		
7	20	266	020		03	00	018						
8	20	231	021		05	00	018						
9	21	231	010		01	20	058						
10	21	318	021		02	00	053						
11	21	391	021		01	40	058						
12	21	391	020		01	00	058						
13	21	231	021		02	00	058						
14	22	301	002		01	00	018						
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kellim 20

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee TRUDY L FROST

Month 12 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	301	009		08	00	018						
2	26	301	004		08	00	018						
3	27	231	021		08	00	018						
4	28	231	010		01	40	058				ENTERED		
5	28	231	021		06	20	058				MAR 02 200		
6	29	231	010		01	20	058				TIME & EFFOR		
7	29	318	021		01	00	058						
8	29	391	021		05	40	058						
9													
10													
11													
12													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kelli M. Ze

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee TRUDY L FROST

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	009		08	00	018						
2	02	318	010		02	00	066						
3	02	318	020		03	00	066						
4	02	231	021		03	00	018						
5	03	231	021		06	00	018						
6	03	318	021		01	00	018						
7	04	318	020		02	00	066						
8	04	318	010		03	00	066						
9	04	231	010		00	20	018						
10	04	231	021		05	40	018						
11	05	231	010		01	20	058						
12	05	231	021		04	40	058						
13	05	391	021		02	00	058						
14													
15													
16													
17													
18													

ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kelli [illegible]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	231	010		012	0	58						
2	22	231	020		02	00	58						
3	22	266	020		024	0	58						
4	22	231	021		01	00	58						
5	23	318	010		014	0	66						
6	23	318	020		03	20	66						
7	23	231	010		01	20	58						
8	23	231	020		02	40	58						
9	24	231	020		03	20	18						
10	24	231	021		04	40	18						
11	25	231	010		02	00	58						
12	25	231	020		06	00	58						
13	25	391	020		01	00	58						
14	26	231	010		01	20	58						
15	26	231	021		06	40	58						
16													
17													
18													

ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kellie M. Zo

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee TRUDY L. FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 04

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	266	020		03	00	018						
2	01	241	020		03	00	018						
3	01	231	021		02	00	018						
4	02	231	020		02	00	058						
5	02	231	021		04	20	058						
6	02	231	010		01	20	058						
7	02	399	020		01	00	058						
8													
9													
10													
11													
12													
13													
14													
15													
16													
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ENTERED
MAY 21 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Kellie M. Lee

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Trudy L Frost

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	301	009		08	00	018						
2	20	318	020		03	20	068						
3	20	391	020		02	20	058						
4	20	318	010		01	20	058						
5	20	231	021		02	00	018						
6	21	231	010		01	20	058						
7	21	318	020		02	00	058						
8	21	231	021		02	40	018						
9	21	266	020		02	00	018						
10	22	231	010		02	20	058						
11	22	231	020		03	40	058						
12	22	231	021		02	00	058						
13	23	231	010		01	20	058						
14	23	231	021		02	00	058						
15	23	391	020		02	00	058						
16	23	391	021		02	40	058						
17													
18													

ENTERED
MAY 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee TRUDY L FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	010		01	00	058						
2	04	391	020		05	40	058						
3	04	231	010		01	20	058						
4	05	318	010		01	40	066						
5	05	318	020		03	20	066						
6	05	231	010		01	20	058						
7	05	231	020		02	40	058						
8	06	231	010		03	20	018						
9	06	231	021		07	40	018						
10	07	231	021		07	40	018						
11	07	231	010		03	20	018						
12	08	231	021		08	00	018						
13													
14													
15													
16													
17													
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ENTERED
AUG 30 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kelli Zar

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee TRUDY L. FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	010		01	00	058						
2	11	391	020		03	00	058						
3	11	231	020		03	00	058						
4	11	231	021		02	00	058						
5	12	318	020		04	00	018						
6	12	231	020		02	00	018						
7	12	231	021		02	00	018						
8	13	231	021		08	00	018						
9	14	301	008		07	00	018						
10	15	301	002		08	00	018						
11													
12													
13													
14													
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ENTERED
AUG 30 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L. Frost

Supervisor's Signature Kelli Fa

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee TRUDY L. FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	266	020		05	20	058						
2	16	231	010		01	20	058						
3	16	231	020		01	20	058						
4	16	275	020		01	20	058						
5	17	318	020		04	00	018			ENTERED			
6	17	266	020		04	00	018			OCT 25 2001			
7	18	231	020		05	00	018			TIME & EFFORT			
8	18	266	020		01	00	018						
9	18	231	021		02	00	018						
10	19	231	010		03	00	018						
11	19	231	020		05	00	018						
12	20	391	020		03	00	058						
13	20	231	010		01	20	058						
14	20	391	021		01	40	058						
15	20	231	021		02	00	058						
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kelli Zan

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee TRUDY L FROST

Month 08 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	231	010		01	20	058						
2	20	231	020		05	40	058						
3	21	231	010		01	20	058						
4	21	231	021		02	40	058						
5	21	231	020		04	00	018						
6	22	301	004		08	00	018						
7	22	231	020		03	00	018						
8	23	391	010		01	20	058						
9	23	391	020		03	40	058						
10	23	266	020		04	00	018						
11	24	231	021		03	00	018						
12	24	301	004		05	00	018						
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kelli M. Lee

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee TRUDY L FROST

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		07	00	058						
2	24	391	010		02	00	058						
3	25	391	020		09	00	058						
4	25	391	010		02	00	058						
5	25	318	020		02	00	058						
6	26	231	010		04	20	058						
7	26	231	020		06	40	058						
8	27	231	010		00	40	018						
9	27	231	021		07	20	018						
10	28	231	010		03	00	018						
11	28	231	021		08	00	018						
12													
13													
14													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Trudy L Frost

Supervisor's Signature Kelli M Zee

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Social Security Number –PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		08	00	058						
2	03	391	020		08	00	058						
3	04	391	020		08	00	058						
4	05	391	020		08	00	058						
5	06	301	008		01	00	058						
6	06	391	020		07	00	058						
7													
8													
9													
10													
11													
12													
13													
14													
15													
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18													

ENTERED
JAN 11 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		07	40	058						
2	09	391	021		01	00	058						
3	10	391	020		08	00	058						
4	11	3901	004		01	20	058						
5	12	391	020		06	00	058						
6	12	3901	004		02	00	058						
7	13	391	020		08	00	058						
8	14	391	020		05	00	058						
9	14	391	010		01	00	058						
10													
11													
12													
13													
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ENTERED
JAN 11 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Month 10 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	020		07	20	058						
2	16	391	010		00	40	058						
3	17	391	020		08	00	058						
4	18	391	020		07	20	058						
5	18	391	010		00	40	058						
6	19	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	391	020		09	00	058						
2	31	391	020		07	00	058						
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JAN 16 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Month 11 Year 00

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
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FEB 02 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	020		08	00	058						
2	07	391	020		08	00	058						
3	08	391	020		02	00	058						
4	08	301	004		06	00	058						
5	09	301	004		08	00	058						
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JAN 31 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Month 11 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	020		08	00	058						
2	14	391	020		08	40	058						
3	15	391	020		08	00	058						
4	16	391	020		08	00	058						
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FEB 02 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		08	00	058						
2	21	391	020		08	00	058						
3	22	391	020		04	20	058						
4	22	301	008		00	40	058						
5	22	301	003		03	00	058						
6	23	301	009		08	00	058						
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FEB 01 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	3011	003		08	00	058						
2	28	3911	020		08	00	058						
3	29	3911	020		08	00	058						
4	30	3011	002		01	20	058						
5	30	3911	020		06	40	058						
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FEB 01 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
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FEB 23 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

ENTERED
FEB 25 2001

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	04	301	002		08	00	058						
2	05	391	020		08	00	058						
3	06	391	020		08	00	058						
4	07	391	020		05	00	058						
5	07	301	004		03	00	058						
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TIME & EFFORT

TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	020		08	00	058						
2	12	391	020		08	00	058						
3	13	391	021		08	00	058						
4	14	391	020		08	00	058						
5	15	301	003		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	020		08	00	058						
2	19	391	020		08	00	058						
3	20	391	020		08	00	058						
4	21	391	020		08	00	058						
5	22	391	020		08	00	058						
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ENTERED
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	301	009		08	00	058						
2	26	301	002		08	00	058						
3	27	391	020		08	00	058						
4	28	391	020		08	00	058						
5	29	391	020		08	00	058						
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ENTERED
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	009		08	00	058						
2	02	391	020		08	00	058						
3	03	391	020		08	00	058						
4	04	391	020		08	00	058						
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APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020		08	00	058						
2	09	301	003		08	00	058						
3	10	391	020		08	00	058						
4	11	391	020		08	00	058						
5	12	391	020		08	00	058						
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APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Social Security Number -PERSONAL IDENTIFIER(S) REDACTED-

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	301	009		08	00	058						
2	16	391	020		08	00	058						
3	17	391	020		08	00	058						
4	18	391	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	301	003		08	00	058						
2	23	301	003		07	00	058						
3	23	391	020		01	00	058						
4	24	301	003		08	00	058						
5	25	391	020		06	40	058						
6	25	301	004		01	20	058						
7	26	391	020		08	00	058						
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ENTERED
MAR 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	020		08	00	058						
2	30	391	020		08	00	058						
3	31	391	020		08	00	058						
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ENTERED
MAR 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number . PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	020		08	00	058						
2	06	391	020		08	00	058						
3	07	391	020		08	00	058						
4	08	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	391	020		09	00	058						
2	13	391	020		08	00	058						
3	14	391	020		05	00	058						
4	15	391	020		09	00	058						
5	16	391	020		09	00	058						
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ENTERED
JUN 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	301	009		08	00	058						
2	20	391	020		09	00	058						
3	21	391	020		03	40	058						
4	21	301	004		04	20	058						
5	22	301	004		08	00	058						
6	23	301	004		08	00	058						
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page (5) X

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	020		02	00	058						
2	26	301	004		06	00	058						
3	27	301	004		08	00	058						
4	28	301	004		03	20	058						
5	28	391	020		04	40	058						
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ENTERED TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya K. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	3911	020		08	00	058						
2	06	3911	020		08	00	058						
3	07	3911	020		08	00	058						
4	08	3911	020		08	00	058						
5	09	3911	020		08	00	058						
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JUN 2 2 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya K Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	3911	020		03	00	058						
2	12	3011	004		05	00	058						
3	13	3011	004		08	00	058						
4	14	3011	004		08	00	058						
5	15	3011	004		08	00	058						
6	16	3011	004		08	00	058						
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JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya K Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Tonya R Hopkins

Social Security Number –PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	391	020		08	00	058						
2	20	391	020		06	00	058						
3	20	301	004		02	00	058						
4	21	391	020		08	00	058						
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JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	020		06	00	058						
2	26	301	004		02	00	058						
3	27	391	020		08	00	058						
4	28	391	020		08	00	058						
5	29	391	020		08	00	058						
6	30	391	020		08	00	058						
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ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Tonya R. Hopkins

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		08	20	058						
2	03	391	020		10	00	058						
3	04	391	020		07	20	058						
4	05	391	020		08	00	058						
5	06	391	020		08	20	058						
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ENTERED
JUL 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Tonya R. Hopkins

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		08	00	058						
2	10	391	020		08	00	058						
3	11	391	020		05	00	058						
4	11	301	008		03	00	058						
5	12	391	020		08	00	058						
6	13	391	020		08	00	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Tonya R. Hopkins

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	020		08	00	058						
2	17	391	020		08	00	058						
3	18	391	020		08	00	058						
4	19	391	020		08	00	058						
5	20	391	020		08	00	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Tonya R. Hopkins

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	020		08	00	058						
2	24	391	020		08	00	058						
3	25	391	020		08	00	058						
4	26	391	020		08	00	058						
5	27	391	020		08	00	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R. Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Tonya R Hopkins

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	301	003		03	20	058						
2	30	391	020		04	40	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Tonya R Hopkins

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	012		05	40	058						
2	02	301	008		02	20	058						
3	03	391	012		09	00	058						
4	04	391	010		01	40	058						
5	04	391	020		06	40	058						
6	05	391	021		08	00	058						
7	06	391	021		06	40	058						
8	06	391	010		01	20	058						
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ENTERED
JAN 1 1 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Month 10 Year 00

Employee Nancy C. Horton

Social Security Number -PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		08	40	058						
2	09	391	010		00	40	058						
3	10	391	020		08	00	058						
4	11	391	020		07	40	058						
5	11	391	010		00	20	058						
6	12	391	020		08	40	058						
7	13	391	020		06	40	058						
8	13	391	010		00	40	058						
9	14	391	010		00	40	058						
10	14	391	020		04	00	058						
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ENTERED JAN 1 2011 TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Month 10 Year 00

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	020		07	40	058						
2	16	391	010		00	20	058						
3	17	391	020		07	00	058						
4	17	391	010		01	00	058						
5	18	391	020		07	20	058						
6	18	391	010		00	40	058						
7	19	391	020		08	00	058						
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ENTERED
DEC 19 2010
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Month 10 Year 00

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	3911	010		00	40	058						
2	23	3911	020		07	40	058						
3	24	3911	020		08	40	058						
4	25	3911	020		08	00	058						
5	26	3911	010		00	20	058						
6	26	3911	020		07	40	058						
7	27	3911	010		00	20	058						
8	27	3911	020		07	20	058						
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ENTERED
JAN 16 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	391	010		00	20	058						
2	30	391	020		07	40	058						
3	31	391	020		08	00	058						
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ENTERED
JAN 16 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	010		02	00	058						
3	02	391	020		02	00	058						
4	03	391	020		06	40	058						
5	03	301	008		01	20	058						
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ENTERED
FEB 07 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 1 1 Year 0 0

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	020		08	20	058				ENTERED		
2	07	391	020		08	00	058				JAN 31 2001		
3	08	391	020		08	00	058				TIME & EFFORT		
4	09	391	020		07	40	058						
5	10	301	009		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	020		09	00	058						
2	14	391	010		00	20	058						
3	14	391	020		08	40	058						
4	15	391	020		08	00	058						
5	16	391	010		00	40	058						
6	16	391	020		07	20	058						
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ENTERED
FEB 07 '00
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		08	00	058						
2	21	391	010		00	20	058						
3	21	391	020		09	00	058						
4	22	391	010		00	20	058						
5	22	391	020		04	20	058						
6	22	301	008		02	00	058						
7	23	301	009		08	00	058						
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ENTERED
FEB 02 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Month 1 1 Year 0 0

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		0820		058						
2	28	391	010		0020		058						
3	28	391	020		0420		058						
4	28	301	004		0300		058						
5	29	391	020		0800		058						
6	30	391	020		0800		058						
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ENTERED
FEB 01 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Hester

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	024		07	40	052						
2	01	391	016		02	60	052						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Hester

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	010		00	40	058						
2	04	391	020		08	20	058						
3	05	391	020		07	00	058						
4	06	391	010		01	20	058						
5	06	391	020		07	20	058						
6	07	391	020		08	00	058						
7	08	391	010		00	20	058						
8	08	391	020		06	00	058						
9	08	301	004		01	00	058						
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ENTERED
FEB 5 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	010		08	00	058						
2	11	391	021		08	00	058						
3	12	391	021		08	00	058						
4	13	391	021		08	00	058						
5	14	391	010		08	00	058						
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ENTERED
MAR 12 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	020		08	20	058						
2	19	391	020		08	40	058						
3	20	391	010		00	20	058						
4	20	391	020		07	40	058						
5	21	391	020		08	20	058						
6	22	391	020		08	00	058						
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MAR 0 2 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	301	009		08	00	058						
2	26	391	020		07	40	058			ENTERED			
3	26	301	008		00	20	058			MAR 0 2 2011			
4	27	391	020		08	00	058			TIME & EFFORT			
5	28	391	020		08	40	058						
6	29	391	020		06	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	009		08	00	058						
2	02	391	020		01	40	058						
3	02	301	004		05	20	058						
4	02	301	003		01	00	058						
5	03	301	004		08	00	058						
6	04	301	003		08	00	058						
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 1 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020		09	40	058						
2	09	391	020		08	20	058						
3	10	391	010		01	00	058						
4	10	391	020		05	00	058						
5	11	391	010		00	40	058						
6	11	391	020		07	20	058						
7	12	301	021		06	00	058						
8	12	391	020		02	20	058						
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	301	009		08	00	058						
2	16	301	003		01	00	058						
3	16	301	008		00	20	058						
4	16	391	020		06	20	058						
5	17	391	020		08	00	058						
6	18	391	020		08	00	058						
7	19	391	020		07	20	058						
8	19	391	010		01	00	058						
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ENTERED
APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 1 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	020		05	00	058						
2	22	301	004		01	40	058						
3	23	391	020		07	20	058						
4	23	391	010		00	20	058						
5	24	391	020		08	00	058						
6	25	391	020		09	20	058						
7	26	391	020		08	20	058						
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ENTERED
MAR 2 9 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	020		08	20	058						
2	30	391	020		08	40	058						
3	31	391	010		00	20	058						
4	31	391	020		07	40	058						
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ENTERED
MAR 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	3910	020		08	20	058						
2	02	3010	002		06	40	058						
3													
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5													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	020		08	20	058						
2	06	391	020		08	40	058						
3	07	391	010		00	40	058						
4	07	391	020		07	40	058						
5	08	391	010		00	40	058						
6	08	391	020		08	00	058						
7	09	391	020		08	00	058						
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ENTERED
JUN 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	391	010		00	20	058						
2	12	391	020		09	20	058						
3	13	391	010		06	40	058						
4	13	391	020		03	20	058						
5	14	391	020		08	00	058						
6	15	391	010		00	20	058						
7	15	391	020		08	40	058						
8	16	391	020		08	00	058						
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ENTERED
JUN 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	3901	009		08	00	058						
2	20	3910	010		00	20	058						
3	20	3910	020		07	40	058						
4	21	3910	010		00	40	058						
5	21	3910	020		07	40	058						
6	22	3910	010		00	40	058						
7	22	3910	020		08	20	058						
8	23	3910	020		07	20	058						
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ENTERED
APR 09 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page X (6)

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	020		08	20	058						
2	27	391	020		08	40	058						
3	28	391	020		07	40	058						
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ENTERED
APR 09 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy Horton RN

Supervisor's Signature Susan Waldrum

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	020		06	00	058						
2	06	391	020		08	20	058						
3	07	391	020		07	20	058						
4	07	391	010		00	40	058						
5	08	391	010		00	20	058						
6	08	391	020		09	40	058						
7	09	391	010		07	40	058						
8	09	391	020		00	20	058						
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ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	391	010		00	40	058						
2	12	391	020		09	00	058						
3	13	391	020		08	40	058						
4	14	391	020		06	00	058						
5	15	391	020		08	00	058						
6	15	391	010		00	20	058						
7	16	391	020		08	00	058						
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ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	391	020		08	00	058						
2	20	391	020		08	00	058						
3	21	391	020		08	00	058						
4	22	391	020		07	40	058						
5	22	391	010		00	20	058						
6	23	391	020		04	00	058						
7	23	391	008		04	00	058						
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ENTERED
JUN 2 2 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	620		08	20	058						
2	26	391	010		00	40	058						
3	27	391	020		07	00	058						
4	28	391	010		00	40	058						
5	28	391	020		07	20	058						
6	29	301	008		04	40	058						
7	29	301	003		03	20	058						
8	30	301	003		08	00	058						
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ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		08	20	058						
2	03	391	020		09	40	058						
3	03	391	010		00	20	058						
4	04	391	020		08	00	058						
5	05	391	020		08	00	058						
6	06	391	010		00	40	058						
7	06	391	020		08	00	058						
8	07	391	010		00	20	058						
9	07	391	020		04	40	058						
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ENTERED
JUL 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	010		01	00	058						
2	09	391	020		09	20	058						
3	10	391	010		00	20	058						
4	10	391	020		08	00	058						
5	11	391	020		08	00	058						
6	12	391	020		06	20	058						
7	13	301	008		09	00	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	010		00	20	058						
2	16	391	020		07	40	058						
3	17	391	010		01	20	058						
4	17	391	020		01	40	058						
5	18	391	010		00	20	058						
6	18	391	020		07	40	058						
7	19	391	010		04	00	058						
8	19	391	020		09	00	058						
9	20	391	010		01	00	058						
10	20	391	020		07	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	010		00	40	058						
2	23	391	020		08	20	058						
3	24	391	010		00	40	058						
4	24	391	020		08	40	058						
5	25	391	010		02	20	058						
6	25	391	020		08	00	058						
7	26	391	010		01	00	058						
8	26	391	020		07	00	058						
9	27	391	010		00	20	058						
10	27	391	020		07	40	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	391	0200		08	00	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number -PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	010		00	20	058						
4	03	391	020		07	40	058						
5	04	391	010		00	20	058						
6	04	391	020		05	40	058						
7	05	391	020		01	40	058						
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ENTERED
JUL 12 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	010		00	20	058						
2	07	391	020		07	40	058						
3	08	391	010		00	20	058						
4	08	391	020		07	40	058						
5	09	391	010		00	40	058						
6	09	391	020		07	20	058						
7	10	391	010		00	40	058						
8	10	391	020		08	20	058						
9	11	391	010		00	40	058						
10	11	391	020		07	20	058						
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ENTERED
JUL 12 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	020		08	20	058						
2	15	391	020		08	20	058						
3	16	391	020		08	00	058						
4	17	391	020		09	20	058						
5	18	301	008		06	00	058						
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ENTERED
AUG 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	020		08	00	058						
2	22	301	002		03	40	058						
3	22	301	008		04	00	058						
4	23	391	020		08	00	058						
5	24	391	020		08	20	058						
6	25	391	020		08	00	058						
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ENTERED
AUG 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	28	301	009		08	00	058						
2	29	391	020		08	40	058						
3	30	391	620		08	00	058						
4	31	391	010		00	20	058						
5	31	391	020		08	00	058						
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ENTERED
AUG 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	620		08	00	058						
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ENTERED
SEP 4 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number [IDENTIFIER(S) REDACTED]

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	010		00	40	058						
2	04	391	020		07	20	058						
3	05	391	010		00	20	058						
4	05	391	020		08	40	058						
5	06	391	020		08	00	058						
6	07	391	020		08	00	058						
7	08	391	020		06	00	058						
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ENTERED
SEP 4 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	010		00	20	058						
2	11	391	020		07	40	058						
3	12	391	010		07	00	058						
4	12	391	020		03	40	058						
5	13	391	010		00	40	058						
6	13	391	020		08	20	058						
7	14	391	010		00	20	058						
8	14	391	020		07	40	058						
9	15	391	020		04	20	058						
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ENTERED
SEP 4 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIERS REDACTED]

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	020		08	20	058						
2	19	391	010		08	00	058						
3	19	391	020		02	00	058						
4	20	391	020		08	00	058						
5	21	391	020		08	00	058						
6	22	391	021		08	20	058						
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ENTERED
SEP 4 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	391	020		08	20	058						
2	26	391	020		08	40	058						
3	26	391	010		00	20	058						
4	27	391	020		06	40	058						
5	27	391	010		00	20	058						
6	28	391	020		08	20	058						
7	29	391	020		08	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		09	40	058						
2	02	391	010		00	20	058						
3	03	391	020		05	00	058						
4	03	391	010		03	00	058						
5	04	301	009		08	00	058						
6	05	301	008		04	20	058						
7	05	301	002		01	40	058						
8	06	301	002		08	00	058						
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ENTERED
OCT 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIERS REDACTED]

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		09	00	058						
2	10	391	010		00	20	058						
3	10	391	020		07	40	058						
4	11	391	010		00	40	058						
5	11	391	020		07	20	058						
6	12	391	010		00	20	058						
7	12	391	020		08	00	058						
8	13	391	010		00	40	058						
9	13	391	020		08	20	058						
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ENTERED
OCT 25 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	010		00	40	058						
2	16	391	020		08	40	058						
3	17	391	010		00	20	058						
4	17	391	020		08	20	058						
5	18	391	010		03	00	058						
6	18	391	021		03	00	058						
7	18	391	020		02	00	058						
8	19	391	010		00	20	058						
9	19	391	020		06	00	058						
10	20	391	020		09	20	058						
11	20	391	010		00	20	058						
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ENTERED
OCT 2 5 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30391	010			00	20	058						
2	30391	020			08	00	058						
3	31391	020			08	20	058						
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ENTERED
OCT 2 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number _____ [illegible]

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	40	058						
2	01	391	010		00	20	058						
3	02	391	020		07	20	058						
4	03	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	020		07	40	058						
2	06	391	010		00	20	058						
3	07	391	020		08	20	058						
4	07	391	010		00	20	058						
5	08	391	020		08	00	058						
6	08	391	010		00	20	058						
7	09	391	020		08	00	058						
8	09	391	010		00	20	058						
9	10	391	020		09	00	058						
10	10	391	010		00	20	058						
11	11	391	020		08	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

OOH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Numbe PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	020		09	00	058						
2	14	391	020		07	40	058						
3	15	391	020		08	20	058						
4	16	391	020		04	00	058						
5	16	301	008		03	00	058						
6	17	301	008		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		08	00	058						
2	21	391	020		08	00	058						
3	22	391	020		08	00	058						
4	23	391	010		03	00	058						
5	23	391	020		09	00	058						
6	24	391	010		08	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	010		00	40	058						
2	27	391	020		07	20	058						
3	28	391	010		00	20	058						
4	28	391	020		07	00	058						
5	29	391	020		08	20	058						
6	30	391	010		00	20	058						
7	30	391	020		08	20	058						
8	31	391	010		04	00	058						
9	31	391	021		05	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	301	009		08	00	058						
2	04	391	020		08	00	058						
3	05	391	020		04	00	058						
4	06	391	010		00	20	058						
5	06	391	020		11	40	058						
6	07	391	010		03	00	058						
7	07	391	021		03	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	020		08	00	058						
2	10	391	010		00	20	058						
3	11	391	020		03	20	058						
4	11	301	014		04	40	058						
5	12	301	014		08	00	058						
6	13	391	020		07	40	058						
7	14	391	010		01	00	058						
8	14	391	020		07	40	058						
9	15	391	010		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number [PERSONAL IDENTIFIER(S) REDACTED]

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	020		08	00	058						
2	18	391	010		00	20	058						
3	18	391	020		08	40	058						
4	19	391	020		07	00	058						
5	20	391	020		08	00	058						
6	21	301	004		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		08	20	058						
2	25	391	010		02	00	058						
3	25	391	020		07	40	058						
4	26	391	020		07	00	058						
5	27	391	020		08	00	058						
6	28	391	020		04	00	058						
7	28	301	008		03	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Michel Jones

Month 02 Year 01

Social Security Number: PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	301	009		08	00	058						
2	20	241	020		08	00	058						
3	21	256	020		01	00	058						
4	21	257	020		01	00	058						
5	21	321	020		01	00	058						
6	21	241	020		05	00	058						
7	22	266	020		03	00	058						
8	22	241	020		03	00	058						
9	22	340	020		01	00	058						
10	22	270	020		01	00	058						
11	23	340	020		02	00	058						
12	23	266	020		00	20	058						
13	23	241	020		00	40	058						
14	23	257	021		03	00	058						
15	23	391	021		02	00	058						
16													
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ENTERED
JUN 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Michel Jones

Supervisor's Signature [signature], RN

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee Michel Jones

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	256	020		03	00	058						
2	05	257	020		03	00	058						
3	05	321	020		02	00	058						
4	05	266	020		00	40	058						
5	06	340	020		05	20	058						
6	06	241	020		03	00	058						
7	07	256	020		03	00	058						
8	07	257	020		03	00	058						
9	07	321	020		02	00	058						
10	08	266	020		02	00	058						
11	08	340	020		02	00	658						
12	08	241	020		03	00	058						
13	08	270	020		01	00	058						
14	09	391	020		05	00	058						
15	09	301	008		02	00	058						
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ENTERED
JUN 25 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Michel Jones RN

Supervisor's Signature Lori Williams, RN

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Michel Jones RN

Month 04 Year 01

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	266	020		02	00	058						
2	09	241	020		01	00	058						
3	09	340	020		04	20	058						
4	09	270	020		01	00	058						
5	10	241	020		08	00	058						
6	11	241	020		04	00	058						
7	11	256	020		02	00	058						
8	11	321	020		01	00	058						
9	11	257	020		01	00	058						
10	12	266	020		04	00	058						
11	12	340	020		04	00	058						
12	13	391	020		00	20	058						
13	13	340	020		04	20	058						
14	13	266	020		02	00	058						
15	13	275	020		01	00	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Michel Jones RN

Supervisor's Signature [signature], RN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Michel Jones RN

Month 04 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	266	020		03	00	058						
2	23	241	020		02	00	058						
3	23	340	020		01	00	058						
4	23	275	020		02	00	058						
5	24	241	020		08	00	058						
6	25	266	020		08	40	058						
7	26	266	020		04	00	058						
8	26	275	020		04	00	058						
9	26	391	020		00	40	058						
10	27	266	020		06	40	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature MJonesRN

Supervisor's Signature Lyn Williams, RN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Michel Jones

Social Security Numbe PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	241	020		05	00	058						
2	01	340	020		03	00	058						
3	02	256	021		05	20	058						
4	02	231	021		02	40	058						
5	03	266	020		02	00	058						
6	03	241	020		04	00	058						
7	03	340	020		02	00	058						
8	04	266	020		02	00	058						
9	04	241	020		01	00	058						
10	04	340	020		02	00	058						
11	04	257	020		01	00	058						
12	04	391	020		02	00	058						
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ENTERED
JUL 12 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature MJonesRN

Supervisor's Signature Lisa Williams, RN

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Janice M. LINN

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	301	010		01	00	018						
2	09	301	021		04	00	018						
3	09	318	021		02	00	018						
4	09	374	021		01	00	018						
5	10	301	010		01	00	018						
6	10	301	021		07	00	018						
7	11	374	021		02	00	018						
8	11	391	021		06	00	018		14				
9	12	301	003		01	00	058						
10	12	301	010		01	00	018						
11	12	301	021		04	00	018						
12	12	266	021		02	00	018						
13	13	301	021		03	00	058						
14	13	301	010		01	00	018						
15	13	391	021		01	00	058		15				
16	13	301	021		03	00	018						
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ENTERED
JUL 16 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Janice M. Linn

Month 04 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	3011	010		01	00	018						
2	02	3011	021		07	00	018						
3	03	3011	003		03	00	018						
4	03	3011	010		01	00	018						
5	03	3011	021		04	00	018						
6	04	3011	021		02	00	058						
7	04	3011	010		01	00	018						
8	04	3011	021		03	00	018						
9	04	3118	021		02	00	018						
10	05	3011	010		01	00	018						
11	05	3011	021		07	00	018						
12	06	3011	021		04	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Janice Linn

Month 04 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	301	010		01	00	018						
2	16	301	021		06	00	018						
3	16	266	021		01	00	018						
4	17	301	002		01	00	058						
5	17	301	021		07	00	058						
6	18	301	010		01	00	018						
7	18	301	021		04	00	018						
8	18	266	021		03	00	018						
9	19	301	021		07	40	058						
10	19	301	010		00	20	058						
11	20	301	021		02	00	058						
12	20	318	021		02	00	058						
13	20	318	021		02	00	058						
14	20	391	021		02	00	058		4				
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JUL 03 2001
TIME & EFFORT

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JUL 02 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Janice M. Linn

Month 04 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	301	010		01	00	018						
2	23	301	021		06	00	018						
3	23	301	021		01	00	058						
4	24	301	010		01	00	018						
5	24	266	021		02	00	018						
6	24	301	021		05	00	018						
7	25	301	021		02	00	058						
8	25	391	021		02	00	058		2				
9	25	318	021		02	00	058						
10	25	374	021		02	00	058						
11	26	266	021		04	00	058						
12	26	241	021		02	00	058						
13	26	301	021		02	00	058						
14	27	301	002		08	00	058						
15													
16													
17													
18													

ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Janice Linn

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	301	021		04	00	058						
2	07	266	021		04	00	058						
3	08	301	010		01	00	018						
4	08	301	021		04	00	018						
5	08	266	021		03	00	018						
6	09	166	149		03	00	018						
7	09	318	010		01	00	018						
8	09	318	021		02	00	018						
9	09	374	021		02	00	018						
10	10	301	010		00	20	058						
11	10	301	021		07	40	058						
12	11	301	021		04	00	058						
13	11	241	021		02	00	058						
14	11	391	021		02	00	058						
15													
16													
17													
18													

ENTERED
JUL 12 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Janice M. Linn

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	[redacted]	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	301	010		01	00	018						
2	23	301	021		05	00	018						
3	23	27[redacted]442			01	00	018						
4	23	266	021		01	00	018						
5	24	301	002		08	00	058						
6	25	301	010		01	00	018						
7	25	301	021		07	00	018						
8	26	301	021		02	00	058						
9	26	266	021		01	00	058						
10	26	[redacted]	021		01	00	058						
11	26	374	021		01	00	058						
12	26	391	021		03	00	058						
13	27	301	010		02	20	058						
14	27	301	021		05	40	058						
15													
16													
17													
18													

ENTERED
OCT 2 0 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Janice M. Linn

Month 08 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	3011	010		01	00	018						
2	20	3011	021		07	00	018						
3	21	3011	021		05	00	058						
4	21	3714	021		03	00	058						
5	22	2666	021		04	00	058						
6	22	3911	021		04	00	058						
7	23	3011	010		03	00	058						
8	23	3011	021		05	00	058						
9	24	3011	021		03	00	058						
10	24	3011	010		01	00	018						
11	24	3011	021		04	00	018						
12													
13													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Wendy Morton

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	359	010		01	00	034						
2	01	359	021		03	00	034						
3	01	360	021		03	00	034						
4	01	399	010		01	00							
5	02	359	010		00	40	026			ENTERED			
6	02	359	021		03	20	026						
7	02	399	021		03	20	026			JUN 12 2001			
8	02	399	010		00	40				TIME & EFFORT			
9													
10													
11													
12													
13										ENTERED			
14										MAY 11 2001			
15										TIME & EFFORT			
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Wendy Morton

Supervisor's Signature Susan Mendoza

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Jane Ann Nichols

Month 01 Year 01

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	009		6	00	058						
2	02	301	000		01	20	018						
3	02	301	001		06	40	018						
4	03	301	001		08	00	058						
5	04	391	001		08	00	058						
6	05	301	003		6	00	058						
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RECEIVED
JUL 02 2001
NEED AFTER FINALED

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 02

Employee J. Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	301	001		08	00	058						
2	09	301	010		01	20	018						
3	09	301	001		05	40	018						
4	10	301	001		08	00	058						
5	11	391	001		08	00	058						
6	12	301	003		02	00	058						
7	12	301	010		01	20	018						
8	12	301	001		04	40	018						
9	[redacted]												
10													
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[illegible] JUL 02 2001

[illegible] FINALED

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 03

Employee J. Nichols

Month 01 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	301	009		08	00	058						
2	16	301	001		08	00	058						
3	17	301	010		01	00	018						
4	17	301	021		06	40	018						
5	18	301	002		08	00	058						
6	19	391	001		08	00	058						
7													
8													
9													
10													
11													
12													
13										DO NOT ENTER			
14										MAY 07 2001			
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16										REC'D AFTER FINALED			
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J. Nichols

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee J. Nichols

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	301	001		6	800	058						
2	27	301	003		0	800	058						
3	28	39I	001		0	800	058						
4	29	301	010		0	120	018						
5	29	301	001		0	640	018						
6	30	39I	001		0	800	058						
7													
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ENTERED
JUN 25 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate. ___

Employee's Signature J Nichols

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee J. Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 6 4 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	001		08	00	058						
2	17	391	001		08	00	058						
3	18	301	002		01	00	058						
4	18	301	010		01	20	018						
5	18	301	001		05	40	018						
6	19	301	010		08	00	018						
7	20	301	001		08	00	058						
8													
9													
10													
11													
12													
13													
14										ENTERED			
15										JUN 27 2001			
16										TIME & EFFORT			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols JUN 2 7 2001 LEGAL SERVICES

Supervisor's Signature Neil Elborn for Steve Ponch

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 03

Employee J. Nichols

Month 05 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	301	010		01	20	018						
2	14	301	001		06	40	018						
3	15	301	001		08	00	058						
4	16	301	010		01	20	018						
5	16	301	001		03	40	018						
6	16	391	001		03	00	058						
7	17	301	010		02	40	058						
8	17	301	001		08	00	058						
9	18	301	010		01	20	018						
10	18	301	001		06	40	018						
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12													
13													
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ENTERED
AUG 0 3 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

JUN 2 2001

Supervisor's Signature Neil Ettonn for Steve Ronck

SERVICES

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Jane Ann Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	001		08	00	058						
2	22	301	003		08	00	058						
3	23	301	010		01	20	018						
4	23	301	001		07	40	018						
5	24	301	001		08	00	058						
6	25	301	008		03	40	058						
7	25	301	002		03	20	058						
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16													
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18													

ENTERED
AUG 0 3 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

Supervisor's Signature Neil Elthon for Steve Ponder

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 03

Employee J. Nichols

Month 06 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	301	002		08	00	058						
2	12	391	001		08	00	058						
3	13	301	010		01	20	018						
4	13	301	001		03	00	018						
5	13	301	001		03	40	058						
6	14	301	010		04	00	018						
7	14	301	001		04	00	018						
8	15	301	001		04	00	058						
9	15	301	010		04	00	058						
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ENTERED
SEP 14 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

Supervisor's Signature Neil Ettorm for Steve Rock

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee J Nichols

Month 07 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	301	001		08	00	058						
2	03	301	010		01	20	018						
3	03	301	001		06	40	018						
4	04	301	009		08	00	058						
5	05	391	001		08	00	058						
6	06	391	001		08	00	058						
7													
8													
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ENTERED
OCT 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols SEP 0 5 2001 Supervisor's Signature Steve W Ronald by LH

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee PEGGY R. PAVIAS

Month 11 Year 00

Social Security Number [redacted] PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	[redacted]												
2	28	301	021		03	20	014						
3	28	241	021		02	40	014						
4	28	166	149		02	00	014						
5	29	301	021		03	00	014						
6	29	241	021		01	00	014						
7	29	166	149		03	00	014						
8	29	396	021		01	00	014						
9	30	301	021		03	20	014						
10	30	396	021		02	00	014						
11	30	166	149		02	40	014						
12													
13													
14													
15													
16													
17													
18													

FEB 13 2001
TIME & EFFORT

ENTERED
JAN 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy R. Pavias

Supervisor's Signature Sidney E. Hartman

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee PEGGY R. PAVIAS

Month 12 Year 00

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	[redacted]												
2	05	301	021		03	40	014						
3	05	241	021		02	00	014						
4	05	166	149		01	00	014						
5	05	3[redacted]	021		01	20	014						
6	06	3[redacted]	021		03	40	014			MAR 09 2001			
7	06	301	021		01	20	014						
8	06	166	149		02	00	014						
9	06	241	021		01	00	014						
10	07	301	021		03	00	014						
11	07	166	149		02	00	014						
12	07	301	003		02	00	014			[illegible]			
13	08	301	021		01	40	014			FEB 09 2001			
14	08	166	149		03	20	014						
15	08	3[redacted]	021		02	00	014			TIME & EFFORT			
16	08	241	021		01	00	014						
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy R. Pavias

Supervisor's Signature Sidney E. Hartman

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee PEGGY R. PAVIAS

Month 03 Year 61

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	12	301	021		01	40	014						
2	12	166	149		02	20	014						
3	12	39	21		02	00	014						
4	12	241	021		02	00	014			ENTERED			
5	13	301	021		02	00	014						
6	13	241	021		02	00	014			JUN 12 2001			
7	13	257	021		01	00	014			TIME & EFFORT			
8	13	166	149		02	00	014						
9	13	39	21		01	00	014						
10	14	301	021		02	00	014						
11	14	166	149		02	40	014						
12	14	241	021		00	20	014			[illegible]			
13	14	257	021		03	00	014			[illegible]			
14	15	301	021		02	40	014			MAY 21 2001			
15	15	241	021		01	20	014			[illegible]			
16	15	257	021		03	00	014			TIME [illegible]			
17	15	166	149		01	00	014						
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy R. Pavias

Supervisor's Signature Sydney C. Hartman

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee PEGGY R. PAULAS

Month 03 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	301	021		01	20	014						
2	19	241	021		00	40	014						
3	19	257	021		01	00	014						
4	19	166	149		01	00	014			ENTERED			
5	19	301	002		04	00	014						
6	20	39[illegible]	021		02	20	014			JUN 12 2001			
7	20	166	149		02	40	014						
8	20	241	021		01	20	014						
9	20	257	021		02	40	014						
10	21	301	021		02	00	014						
11	21	241	021		01	40	014						
12	21	257	021		01	20	014						
13	21	39[illegible]	021		02	40	014						
14	21	166	149		00	20	014			MAY 21 2001			
15	22	301	021		03	00	014						
16	22	166	149		02	00	014						
17	22	38[illegible]	021		03	00	014						
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy R. Paulas

Supervisor's Signature Sidney E. Hartman

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee PEGGY R. PAULAS

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 0 3 Year 0 1

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	26	301	021		03	20	014						
2	26	241	021		02	20	014						
3	26	166	1496		01	00	014						
4	26	391	021		01	20	014						
5	27	301	021		02	40	014						
6	27	166	1496		01	20	014			ENTERED			
7	27	391	021		00	20	014			JUN 12 2001			
8	27	241	021		01	00	014			TIME & EFFORT			
9	27	301	003		02	40	014						
10	28	301	021		03	00	014						
11	28	241	021		02	00	014						
12	28	166	1496		02	00	014						
13	28	391	021		01	00	014			[illegible]			
14	29	301	021		03	00	014						
15	29	241	021		03	20	014			MAY 21 2001			
16	29	257	021		01	40	014			TIME & EFFORT			
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy R. Paulas

Supervisor's Signature Sidney E. Hartman

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee PEGGY R. PAVIAS

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	301	021		03	00	014						
2	02	241	021		01	20	014						
3	02	391	021		02	40	014						
4	02	166	149		01	00	014						
5	03	301	021		03	00	014						
6	03	241	021		04	40	014						
7	03	301	023		00	20	014						
8	04	301	003		08	00	014						
9	05	166	149		01	00	014						
10	05	301	021		03	00	014						
11	05	257	021		02	00	014						
12	05	391	021		02	00	014						
13													
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18													

ENTERED
JUL 18 2001
TIME & EFFORT

ENTERED
JUL 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy R. Pavias

Supervisor's Signature Sidney E Hartman

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee PEGGY R. PAVIAS

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	301	021		03	00	014						
2	09	257	021		02	00	014						
3	09	391	021		02	00	014						
4	09	241	021		01	00	014						
5	10	301	021		02	00	014						
6	10	241	021		03	00	014						
7	10	257	021		02	00	014						
8	10	166	149		01	00	014						
9	11	241	021		02	40	014						
10	11	257	021		01	20	014						
11	11	391	021		01	40	014						
12	11	166	149		01	20	014						
13	11	301	003		01	00	014						
14	12	301	021		03	00	014						
15	12	391	021		02	00	014						
16	12	166	149		02	00	014						
17	12	301	003		01	00	014						
18													

ENTERED
JUL 03 2001
TIME & EFFORT

ENTERED
JUL 02 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Peggy R. Pavias

Supervisor's Signature Shirley E. Hartman

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Remedios Torres

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	021		08	00	058						
2	02	391	021		08	00	058						
3	03	391	021		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Torres

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Remedios TIRRES Torres

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	021		02	00	058						
2	06	391	020		06	00	058						
3	07	391	010		00	20	058						
4	07	391	020		06	40	058						
5	07	391	021		01	00	058						
6	08	391	010		00	40	058						
7	08	391	020		06	00	058						
8	08	391	021		01	20	058						
9	09	391	010		00	20	058						
10	09	391	020		06	40	058						
11	09	391	021		01	00	058						
12	10	391	010		00	20	058						
13	10	391	020		07	40	058						
14	11	391	010		00	20	058						
15	11	391	021		06	40	058						
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Torres

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Remedios Tieles

Month 08 Year 01

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	020		06	00	058						
2	13	391	021		02	00	058						
3	14	391	020		08	00	058						
4	15	391	021		04	00	058						
5	15	391	020		04	00	058						
6	16	391	021		06	00	058						
7	16	391	020		02	00	058						
8	17	391	020		06	00	058						
9	17	391	021		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tieles

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Remedios Torres

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	021		04	00	058						
2	20	391	020		04	00	058						
3	21	391	020		06	00	058						
4	21	391	021		02	00	058						
5	22	391	020		06	00	058						
6	22	391	021		02	00	058						
7	23	391	020		02	00	058						
8	23	391	021		06	00	058						
9	24	391	020		06	00	058						
10	24	391	021		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Torres

Supervisor's Signature Susan Waldron

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Remedios Lucero

Month 09 Year 01

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	301	009		08	00	058						
2	04	391	020		05	00	058						
3	04	391	021		03	00	058						
4	05	391	020		04	00	058						
5	05	391	021		04	00	058						
6	06	391	020		03	00	058						
7	06	391	021		05	00	058						
8	07	391	020		02	00	058						
9	07	391	021		06	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Lucero

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Renea Jones

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	021		04	00	058						
2	10	391	020		04	00	058						
3	11	391	020		02	00	058						
4	11	3[illegible]1	014		06	00	058						
5	12	3[illegible]1	014		08	00	058						
6	13	391	021		06	00	058						
7	13	391	020		02	00	058						
8	14	391	020		04	00	058						
9	15	391	020		06	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Renea Jones

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Remedios Luis

Month 09 Year 01

Social Security Number – PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	020		04	00	058						
2	17	391	021		03	00	058						
3	17	391	021		01	00	058						
4	18	391	020		06	00	058						
5	18	391	021		02	00	058						
6	19	391	020		05	00	058						
7	19	391	021		03	00	058						
8	20	391	020		04	00	058						
9	20	391	021		04	00	058						
10	21	391	020		04	00	058						
11	21	391	021		04	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Luis

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Remedios Luis

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	020		04	00	058						
2	24	391	021		04	00	058						
3	25	391	020		05	00	058						
4	25	391	021		03	00	058						
5	26	391	020		04	00	058						
6	26	391	021		04	00	058						
7	27	391	020		04	00	058						
8	27	391	021		04	00	058						
9	28	391	020		06	00	058						
10	28	391	021		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Luis

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Month 10 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		08	00	058						
2	03	391	010		00	40	058						
3	03	391	020		07	20	058						
4	04	391	020		08	00	058						
5	05	391	010		02	40	058						
6	05	391	020		05	20	058			ENTERED			
7	06	391	010		01	20	058			DEC 19 2000			
8	06	391	021		02	00	058			TIME & EFFORT			
9	06	391	020		04	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		08	00	058						
2	09	238	021		01	00	058						
3	10	391	010		00	40	058						
4	10	391	020		07	20	058						
5	10	288	021		02	20	058						
6	11	391	020		08	00	058			ENTERED			
7	12	391	020		08	00	058			DEC 19 2000			
8	13	391	010		06	00	058			TIME & EFFORT			
9	13	391	020		02	00	058						
10	14	391	010		01	20	058						
11	14	391	020		04	00	058						
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16													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

ENTERED

JAN - 7 2001

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 00

TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	020		08	00	058						
2	17	391	010		01	00	058						
3	17	391	020		07	00	058						
4	18	391	010		01	20	058						
5	18	391	020		06	40	058						
6	19	391	020		08	00	058						
7	20	391	020		05	20	058						
8	20	301	008		02	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

ENTERED Page 4

JAN 7 2001 Month 10 Year 00

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	020		08	00	058						
2	24	391	021		08	00	058						
3	25	391	020		08	00	058						
4	26	391	020		07	00	058						
5	26	301	003		01	00	058						
6	27	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

ENTERED
JAN 17 2001

Month 10 Year 00

TIME & EFFORT

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Number Children	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	391	010		01	00	058						
2	30	391	020		09	20	058						
3	31	391	010		01	00	058						
4	31	391	020		06	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	020		07	00	058						
4	03	301	008		01	00	058						
5													
6													
7											ENTERED		
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9											TIME & EFFORT		
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Month 11 Year 00

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	020		08	00	058						
2	07	391	020		08	00	058						
3	08	391	010		01	00	058						
4	08	391	020		07	00	058						
5	09	391	010		01	40	058						
6	09	391	020		08	20	058						
7	10	301	009		08	00	058						
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ENTERED
FEB 05 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	301	008		01	00	058						
2	14	391	010		03	40	058						
3	14	391	020		08	20	058						
4	15	391	021		08	00	058						
5	16	391	021		08	00	058						
6	17	391	010		03	40	058						
7	17	391	021		07	20	058						
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ENTERED
JAN 31 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron [redacted]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	20	391	020		07	00	058						
2	21	391	010		00	40	058						
3	21	391	020		07	20	058						
4	22	391	021		03	00	058						
5	22	391	010		06	00	058						
6	23	301	009		08	00	058						
7	24	301	009		08	00	058						
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ENTERED
JAN 31 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 11 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		08	00	058						
2	28	391	010		01	00	058						
3	28	391	020		07	00	058						
4	29	391	020		08	00	058						
5	30	391	010		01	00	058						
6	30	391	020		09	20	058						
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ENTERED
JAN 31 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		05	40	058						
2													
3													
4													
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7													
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11													
12													
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ENTERED
MAR 01 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	020		08	00	058						
2	05	391	010		01	00	058						
3	05	391	020		07	00	058						
4	06	391	020		08	00	058						
5	07	391	010		01	00	058						
6	07	391	020		07	00	058						
7	07	391	021		01	00	058						
8	08	391	020		08	00	058						
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ENTERED
MAR 0 1 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 12 Year 00

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	010		08	00	058						
2	11	391	021		08	00	058						
3	12	391	021		08	00	058						
4	13	391	021		08	00	058						
5	14	391	010		08	00	058						
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MAR 0 2 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Month 12 Year 00

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	18	391	020		08	00	058						
2	19	391	020		08	00	058						
3	20	391	020		08	00	058						
4	21	391	020		08	00	058			ENTERED			
5	22	391	020		03	40	058			MAR 0 2 2001			
6	22	301	008		04	20	058			TIME & EFFORT			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	3011	009		08	00	058						
2	02	3911	020		08	00	058						
3	03	3911	020		08	00	058						
4	04	3911	020		08	00	058						
5	05	3911	020		08	00	058						
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ENTERED APR 04 2001 TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	021		07	20	058						
2	08	391	010		00	40	058						
3	09	391	020		08	20	058						
4	09	391	010		04	00	058						
5	10	391	021		07	00	058						
6	10	391	010		03	20	058						
7	11	391	020		07	00	058						
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APR 04 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	301	009		08	00	058						
2	16	391	020		08	00	058						
3	17	391	020		08	00	058						
4	18	391	020		07	00	058						
5	18	391	010		01	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	020		06	40	058						
2	22	391	010		01	20	058						
3	23	391	020		08	40	058						
4	23	391	010		02	20	058						
5	24	391	020		08	00	058						
6	25	391	020		08	00	058						
7	26	391	020		10	00	058						
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ENTERED
MAR 2 9 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 01 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	020		08	00	058						
2	30	391	020		08	00	058						
3	31	391	020		08	00	058						
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MAR 29 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	020		08	00	058						
2	06	391	020		08	00	058						
3	07	391	020		08	00	058						
4	08	391	020		08	00	058						
5	09	301	008		08	00	058						
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MAY 2 9 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	391	020		08	40	058						
2	13	391	010		06	00	058						
3	13	391	021		07	00	058						
4	14	391	010		01	00	058						
5	14	391	020		07	00	058						
6	15	391	020		08	00	058						
7	16	391	020		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		00	20	058						
2	01	391	020		07	40	058						
3	02	391	010		01	00	058						
4	02	391	020		07	00	058						
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MAY 24 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		07	20	058						
2	27	391	010		00	40	058						
3	28	391	020		07	00	058						
4	28	391	010		01	00	058						
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ENTERED
MAY 2 4 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 02 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	301	009		08	00	058						
2	20	391	020		08	40	058						
3	20	391	010		01	00	058						
4	21	391	020		06	40	058						
5	21	391	010		01	20	058						
6	22	391	020		06	20	058						
7	23	391	020		06	40	058						
8	23	391	010		01	20	058						
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ENTERED
MAY 3 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		07	40	058						
3	02	391	010		00	20	058						
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ENTERED
JUN 25 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	05	391	020		08	00	058						
2	06	391	010		01	00	058						
3	06	391	020		07	00	058						
4	07	391	020		08	00	058						
5	08	391	010		01	00	058						
6	08	391	020		03	00	058						
7	08	301	002		04	00	058						
8	09	391	020		08	00	058						
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ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	12	39 1	020		06	40	058						
2	12	238	021		01	20	058						
3	13	391	010		01	00	058						
4	13	391	020		07	00	058						
5	14	391	010		03	00	058						
6	14	391	020		06	00	058						
7	15	391	021		06	00	058						
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ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	19	3011	008		0200	058							
2	19	3011	003		0600	058							
3	20	3911	020		0800	058							
4	21	3911	020		0800	058							
5	22	3911	020		0800	058							
6	23	3911	020		0800	058							
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 03 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	26	391	010		00	20	058						
2	26	391	020		07	40	058						
3	27	391	010		01	20	068						
4	27	391	020		06	40	058						
5	28	391	020		08	00	058						
6	29	391	020		08	00	058						
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ENTERED
JUN 22 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	010		01	00	058						
2	16	391	020		07	00	058						
3	17	391	010		01	00	058						
4	17	391	020		07	00	058						
5	18	391	010		01	20	058						
6	18	391	020		06	40	058						
7	19	391	010		03	40	058						
8	19	391	020		07	00	058						
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JUN 27 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		08	00	058						
2	03	391	020		08	00	058						
3	04	391	020		08	00	058						
4	05	391	020		05	00	058						
5	06	391	020		08	00	058						
6	06	391	010		00	40	058						
7	07	391	020		04	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	301	003		08	00	058						
2	10	391	010		00	40	058						
3	10	391	020		07	20	058						
4	11	391	020		08	00	058						
5	12	391	020		08	00	058						
6	13	391	010		01	20	058						
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JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron
PERSONAL IDENTIFIER(S) REDACTED

Social Security Number ___

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	010		01	00	058						
2	23	391	020		07	00	058						
3	24	391	010		01	00	058						
4	24	391	020		07	00	058						
5	25	391	020		08	00	058						
6	26	391	020		06	40	058						
7	26	391	010		00	20	058						
8	26	391	021		01	00	058						
9	27	391	010		00	20	058						
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JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 6

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 04 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	30	391	020		08	40	058						
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ENTERED
JUL 10 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	010		01	20	058						
3	02	391	020		06	40	058						
4	03	391	010		00	40	058						
5	03	391	020		07	20	058						
6	04	391	010		00	40	058						
7	04	391	020		08	20	058						
8	05	391	020		02	40	058						
9	05	391	010		00	20	058						
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JUL 13 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	07	391	020		08	00	058						
2	08	391	020		09	40	058						
3	09	391	020		04	00	058						
4	09	391	021		04	00	058						
5	10	391	010		01	00	058						
6	10	391	020		07	40	058						
7	11	391	020		02	20	058						
8	11	301	008		05	40	058						
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ENTERED
JUL 13 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	14	391	020		08	00	058						
2	15	391	020		08	00	058						
3	16	391	020		08	00	058						
4	17	391	020		08	20	058						
5	18	391	010		00	40	058						
6	18	391	020		07	20	058						
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AUG 06 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 05 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	21	391	020		08	00	058						
2	22	391	020		08	00	058						
3	23	301	008		08	00	058						
4	24	301	008		08	00	058						
5	25	301	002		08	00	058						
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TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	04	391	020		08	00	058						
2	05	391	010		02	40	058						
3	05	391	020		05	20	058						
4	06	391	020		08	00	058						
5	07	391	010		02	40	058						
6	07	391	021		06	00	058						
7	08	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	11	391	020		06	00	058						
2	11	391	021		02	00	058						
3	12	391	020		08	00	058						
4	13	391	020		08	00	058						
5	14	391	020		08	00	058						
6	15	301	004		03	40	058						
7	15	391	020		04	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 06 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	25	391	010		01	00	058						
2	25	391	020		07	00	058						
3	26	391	010		01	00	058						
4	26	391	020		08	00	058						
5	27	391	020		08	00	058						
6	28	391	020		08	00	058						
7	29	391	010		01	00	058						
8	29	391	020		07	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [illegible]

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	02	391	020		07	20	058						
2	02	391	010		00	40	058						
3	03	391	020		05	00	058						
4	03	391	010		03	00	058						
5	04	301	009		08	00	058						
6	05	391	020		08	00	058						
7	06	391	010		01	20	058						
8	06	391	020		06	40	058						
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ENTERED
DEC 19 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	23	391	020		08	00	058						
2	24	391	010		01	00	058						
3	24	391	020		08	20	058						
4	25	391	020		06	40	058						
5	26	301	002		08	00	058			ENTERED			
6	27	391	010		02	00	058			DEC 12 2001			
7	27	391	021		06	00	058			TIME & EFFORT			
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Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Column 2	Column 3	Column 4
1	30	391	010		01	00	058						
2	30	391	020		07	00	058						
3	31	391	010		02	00	058						
4	31	391	021		06	00	058						
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ENTERED
DEC 19 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	09	391	020		08	00	058						
2	10	391	010		01	00	058						
3	10	391	020		07	00	058						
4	11	391	010		01	00	058						
5	11	391	020		07	00	058						
6	12	391	010		00	20	058						
7	12	391	020		07	40	058						
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ENTERED
DEC 19 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 07 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	16	391	010		01	40	058						
2	16	391	020		08	20	058						
3	17	391	010		00	40	058						
4	17	391	020		07	20	058						
5	18	301	003		04	20	058						
6	19	391	010		00	40	058						
7	19	391	020		08	20	058			ENTERED			
8	20	391	020		08	40	058			DEC 19 2001			
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		00	20	058						
2	01	391	020		08	40	058						
3	02	391	010		00	20	058						
4	02	391	020		08	40	058						
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Employee's Signature Susan Waldron

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	06	391	020		08	00	058						
2	07	391	010		00	20	058						
3	07	391	020		08	00	058						
4	08	391	010		01	00	058						
5	08	391	020		07	20	058						
6	09	391	010		00	40	058						
7	09	391	020		08	20	058						
8	10	391	010		00	20	058						
9	10	391	020		08	20	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	13	391	020		08	00	058						
2	14	391	020		08	00	058						
3	15	391	010		01	00	058						
4	15	391	020		07	40	058						
5	16	391	010		01	00	058						
6	16	391	020		08	20	058						
7	17	391	020		04	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	20	391	020		08	20	058						
2	21	391	010		00	40	058						
3	21	391	020		07	20	058						
4	22	391	010		00	40	058						
5	22	391	020		08	00	058						
6	23	391	010		04	00	058						
7	23	391	021		04	40	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 08 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	27	391	020		08	00	058						
2	28	391	010		01	00	058						
3	28	391	020		07	00	058						
4	29	391	020		08	00	058						
5	30	391	010		00	40	058						
6	30	391	020		08	00	058						
7	31	391	010		01	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron PERSONAL IDENTIFIER(S) REDACTED

Social Security Number —

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	03	301	009		08	00	058						
2	04	391	020		08	00	058						
3	05	391	020		08	00	058						
4	06	391	010		00	40	058						
5	06	391	020		07	20	058						
6	07	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	10	391	020		08	00	058						
2	10	391	021		01	00	058						
3	11	391	020		03	00	058						
X	11	301	014		05	00	058						
X	12	301	014		08	00	058						
6	13	391	020		07	00	058						
7	13	391	010		01	00	058						
8	14	391	020		08	00	058						
9	14	391	010		00	40	058						
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Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	17	391	020		08	00	058						
2	18	391	010		01	00	058						
3	18	391	020		07	00	058						
4	19	391	020		07	00	058						
5	20	391	010		00	40	058						
6	20	391	020		08	20	058						
7	21	391	010		00	40	058						
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Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Page 4

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 09 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	24	391	010		00	40	058						
2	24	391	020		07	00	058						
3	25	391	010		01	20	058						
4	25	391	021		09	00	058						
5	26	391	010		00	40	058						
6	26	391	020		07	20	058						
7	27	391	020		06	00	058						
8	28	391	020		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Time And Effort Cost Accumulation Schedule

December 26, 2001
Prepared By CB

Grant Name: Conduct Site Spec. Activities
Grant Number: U50 / ATU686520-03
Grant Period: 09/29/2000 TO 09/28/2001
Program Code: 391

	TE009				PGM 244					
Year\Mont	On-Salary	On-Fringe	Off-Salary	Off-Fringe	On-Salary	On-Fringe	Off-Salary	Off-Fringe	Total Salary	Total Fringe
200010	683.70	179.70	7,470.18	2,178.32	0.00	0.00	0.00	0.00		
200011	611.30	174.39	7,007.64	2,051.55	0.00	0.00	0.00	0.00		
200012	654.86	186.86	7,847.07	2,274.43	0.00	0.00	0.00	0.00		
200101	460.39	133.70	6,937.97	2,045.11	0.00	0.00	0.00	0.00		
200102	396.75	115.23	8,620.78	2,467.63	0.00	0.00	0.00	0.00		
200103	468.06	136.57	7,788.70	2,327.37	0.00	0.00	0.00	0.00		
200104	471.61	136.97	8,681.27	2,528.27	0.00	0.00	0.00	0.00		
200105	359.33	104.35	6,371.21	1,739.12	0.00	0.00	0.00	0.00		
200106	415.47	120.66	7,268.15	1,969.40	0.00	0.00	0.00	0.00		
200107	437.93	147.38	6,356.55	1,761.56	0.00	0.00	0.00	0.00		
200108	325.64	109.59	7,512.53	1,792.46	0.00	0.00	0.00	0.00		
200109	297.77	98.06	8,045.65	2,302.58	0.00	0.00	0.00	0.00		
Total	5,582.81	1,643.48	89,907.70	25,437.80	0.00	0.00	0.00	0.00		
		[redacted]			TOTAL					
200010	64.62	16.95	1,134.12	309.78	748.32	196.65	8,604.30	2,488.10	9,352.62	2,684.75
200011	67.47	17.92	831.62	230.11	678.77	192.31	7,839.26	2,281.66	8,518.03	2,473.97
200012	71.85	19.51	1,200.26	334.64	726.71	206.37	9,047.33	2,609.07	9,774.04	2,815.44
200101	25.66	6.62	885.58	244.75	486.05	140.32	7,823.55	2,289.86	8,309.60	2,430.18
200102	18.92	4.93	1,028.27	277.73	415.67	120.16	9,649.05	2,745.36	10,064.72	2,865.52
200103	21.69	5.67	1,057.78	297.28	489.75	142.24	8,846.48	2,624.65	9,336.23	2,766.89
200104	22.73	5.73	1,088.15	304.96	494.34	142.70	9,769.42	2,833.23	10,263.76	2,975.93
200105	17.29	4.56	640.43	178.57	376.62	108.91	7,011.64	1,917.69	7,388.26	2,026.60
200106	20.05	5.02	868.48	233.18	435.52	125.68	8,134.63	2,202.58	8,570.15	2,328.26
200107	17.93	4.87	635.07	187.73	455.86	152.25	6,991.62	1,949.29	7,447.48	2,101.54
200108	17.61	4.69	926.08	270.38	343.25	114.28	8,438.61	2,062.84	8,781.86	2,177.12
200109	22.60	6.38	1,783.35	535.80	320.37	104.46	9,829.00	2,838.38	10,149.37	2,942.84
Total	[redacted]	[redacted]	[redacted]	[redacted]	5,971.23	1,746.33	101,984.89	28,842.71	107,956.12	30,589.04

PGM 301
$15,973.37

Adjustments to TE005 Report
9/29/2000 to 9/28/2001

	Total Hours	Total Cost	Per Hour Rate	Hours (Short)/Long	Cost Adjustment
1 K. Cornell	327.43	$11,958.73	$36.52	1.00	**$36.52**
2 S. Fouquet	18.36	566.70	30.87	2.00	**61.74**
3 T. Frost	69.37	2,303.78	33.21	(6.67)	**(221.51)**
4 N. Horton	1,886.95	42,495.16	22.52	(16.33)	**(367.75)**
5 J. Nichols	67.02	2,418.77	36.09	24.00	**866.16**
6 P. Pavlas	40.02	727.52	18.18	(6.00)	**(109.08)**
7 R. Tirres	339.65	3,058.50	9.00	(48.67)	**(438.03)**
8 S. Waldron	1,857.02	37,397.91	20.14	0.33	**6.65**
					$ (165.30)

FEES

9/29/2000 to 9/28/2001

Claims	3,240.00
PROGCOST - Fees	999.47
Total Fees	$ 4,239.47

Claims are the direct costs and PROGCOST are the allocated costs. These are costs for professional services. Examples might be things like developing curricula for training materials or speaker fees. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X027170	216324

FOR AGENCY USE WARRANT # 7526430 DATE: 11/30/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	1582	000000000	1,350.00

CLAIM OF:
INTEGRIS BAPTIST REG HLTH CTR
730584411 2161632 4

FOR $ 1,350.00

AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	1,350.00
003		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/14/2001	NOV 2001	1,350.00

THIS SPACE FOR AGENCY USE

400BT12 000235NW97 1582AAAAAX 1350.00

J/E XREF:

VENDOR: INTEGRIS BAPTIST REG HLTH CTR
ADDRESS: ATTN: ANGEL HILL ACCTG
ADDRESS: PO BOX 1207
CITY/ST/ZIP: MIAMI OK 74355

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

11/27/2001
Date

Agency, Bd or Div. Use

2/6324

INVOICE

RECEIVED

2001 NOV 15 P 1:01

BAPTIST REGIONAL HEALTH CENTER
Attn: Angel Hill, Accounting
200 2nd S.W. - P.O. Box 1207
Miami, Oklahoma 74355
918-540-7282
FEI # 73-0584411

14-Nov-01

OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1299

PO# ~~7076931~~ X027170

Period covered @ $135.00/day:

07/16/2001	Jelly Bean Daycare	Commerce, OK	135.00
07/17/2001	Kelly's Corner	Miami, OK	135.00
07/19/2001	Joyful Learning Center	Miami, OK	135.00
08/07/2001	Nichols Elementary	Miami, OK	135.00
08/08/2001	Quapaw Head Start	Miami, OK	135.00
08/09/2001	Miami Head Start	Miami, OK	135.00
08/11/2001	Wal-Mart Health Fair	Miami, OK	135.00
09/10/2001	Commerce Middle School	Commerce, OK	135.00
09/14/2001	Fairland Middle School	Fairland, OK	135.00
09/15/2001	REC Day	Grove, OK	135.00

09

If you have questions regarding this invoice please contact Jennifer Hessee at (918)540-7492.

730584411
X027170 000235NW97
003 4001302
35005 1582AX
2/6324
11-21-01

Previous Balance

PLEASE PAY THIS AMOUNT **$ 1,350.00**

Grant close-out

Financial Management Service

Return#: 15853

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To:

Ken Cadaret/Family Health Services

Vendor Name: Baptist Regional Health Center

Vendor Number:

Invoice Number: July - Sept 2001 Invoice Date: 11/14/2001 Amount: $1,350.00

Order Number: X027170 Audited By: Ronney Maxwell Date Rejected: 11/19/2001

Funding

- ☐ Funding Not Indicated
- ☐ Does Not Match Encumbrance
- ☐ Invalid Fund
- ☐ Invalid Account
- ☐ Invalid Sub-Activity
- ☐ Invalid Object Code

Signature

- ☐ Vendor Signature
- ☐ Supervisor Signature
- ☐ Funding Block Signature

Verify The Following:

- ☐ Verify Vendor FEI #
- ☐ Verify Order #

Not Enough Allotment:

- ☐ 1st Quarter Allotment Insufficient
- ☐ 2nd Quarter Allotment Insufficient
- ☐ 3rd Quarter Allotment Insufficient
- ☐ 4th Quarter Allotment Insufficient

Need Additional Information:

- ☐ Certified Invoice Copy
- ☐ Proof of Delivery
- ☐ Notary Seal Missing
- ☐ Notary Signature Missing
- ☐ Notary County or State Incomplete
- ☐ Notary Expired (Not Valid)
- ☐ Changes Need Justification
- ☐ Changes Need Authorizing Initials
- ☐ Item Not Found

Mathematical Errors:

- ☐ Calculations Inaccurate
- ☐ Cross Footing Inaccurate
- ☐ Price Discrepancy

Encumbrance Problem:

- ☐ Invoice Exceeds Contract
- ☐ Invoice Exceeds Encumbrance
- ☐ Order Finalled

Required Dates:

- ☐ Invoice Date Prior to Date of Service
- ☐ Notary Date Prior to Date of Invoice
- ☐ Notary Date Prior to Date of Service

Other Remarks or Comments:

For your approval

K- Parker 11/21/01

11/21

Please Return This Document To Financial Management

1000 NE 10st Oklahoma City, OK 73117-1299 Room 315 (405) 271-4042

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X027170	200563

FOR AGENCY USE
WARRANT # 7013628 DATE: 07/09/2001

CLAIM OF:
INTEGRIS BAPTIST REG HLTH CTR
730584411

2005 63

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	1511	932000000	1,080.00

FOR
$ 1,080.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	1,080.00
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010427

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/21/2001	MAY2001	1,080.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 1511AAAAAX 1080.00

J/E XREF:

VENDOR: INTEGRIS BAPTIST REG HLTH CTR
ADDRESS: P. O. BOX 1590
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74355

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

07/03/2001
Date

Agency, Bd or Div. Use

X027170

INVOICE

BAPTIST REGIONAL HEALTH CENTER
Attn: Angel Hill, Accounting
200 2nd S.W. - P.O. Box 1207
Miami, Oklahoma 74355
918-540-7282
FEI # 73-0584411

PURCHASE DOCUMENT | ACCOUNT NO.
COMPLETE | PARTIAL | FUND NO.
SUB ACTIVITY | OBJECT CODE
MATH | ENTERED | CLAIM NUMBER
INVOICE APPROVED | DATE 05-31-2001

May 21, 2001

04-27-2001

OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1299

~~PO# T078931~~ X027170

Period covered @ $135.00/day:	
04/06/2001 FAIRLAND, OK	135.00
04/09/2001 WYANDOTTE, OK	135.00
04/16/2001 PICHER, OK	135.00
04/19/2001 AFTON, OK	135.00
04/20/2001 AFTON, OK	135.00
04/23/2001 QUAPAW, OK	135.00
04/24/2001 QUAPAW, OK	135.00
04/27/2001 MIAMI, OK	135.00
If you have questions regarding this invoice please contact Dave Simpson at (918)540-7624.	
Previous Balance	
PLEASE PAY THIS AMOUNT	**$ 1,080.00**

May 16, 2001

Angel,

The following is a list of the days and dates the Health Express was used by the Ottawa County Health Department. Please bill the Oklahoma State Department of Health per our contract.

April 6th	Fairland, Oklahoma
April 9th	Wyandotte, Oklahoma
April 16th	Picher, Oklahoma
April 19th	Afton, Oklahoma
April 20th	Afton, Oklahoma
April 23rd	Quapaw, Oklahoma
April 24th	Quapaw, Oklahoma
April 27th	Miami, Oklahoma

8 days @ $135 per day = $1080.

If you have any questions please call, 540-7624.

Thanks

Dave

15020

Ken Cadaret/Disorders

Baptist Regional Health Center | 730584411

MAY 16,2001 | 5/21/01 | $1,080.00

X027170 | Patricia Farmer | 5/31/01

For your approval

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X027170	117028

FOR AGENCY USE: WARRANT # 7541097 DATE: 12/11/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	1511	932340000	810.00

CLAIM OF:
INTEGRIS BAPTIST REG HLTH CTR
730584411

1 1 7 0 2 8

FOR
$ 810.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	810.00
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001027

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/15/2000	OCT 00	810.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 1511AAAAAX 810.00

J/E XREF:

VENDOR: INTEGRIS BAPTIST REG HLTH CTR
ADDRESS: P. O. BOX 1590
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74355

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

12/07/2000

Title Date

Agency, Bd or Div. Use

117028 [illegible]

INVOICE

BAPTIST REGIONAL HEALTH CENTER
Attn: Angel Hill, Accounting
200 2nd S.W. - P.O. Box 1207
Miami, Oklahoma 74355
918-540-7282
FEI # 73-0584411

15-Nov-00

OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1299

PO# T078931

Period covered @ $135.00/day:		
10/09/2000	Wyandotte Elementary	135.00
10/13/2000	Afton Elementary	135.00
10/14/2000	Wyandotte Health Fair	135.00
10/16/2000	Picher Elementary	135.00
10/23/2000	Quapaw Elementary	135.00
10/27/2000	Miami Middle School	135.00

X027170 | 000135 dw97
001 | 400BT11
42000 | 1511 A-X
12-06-00

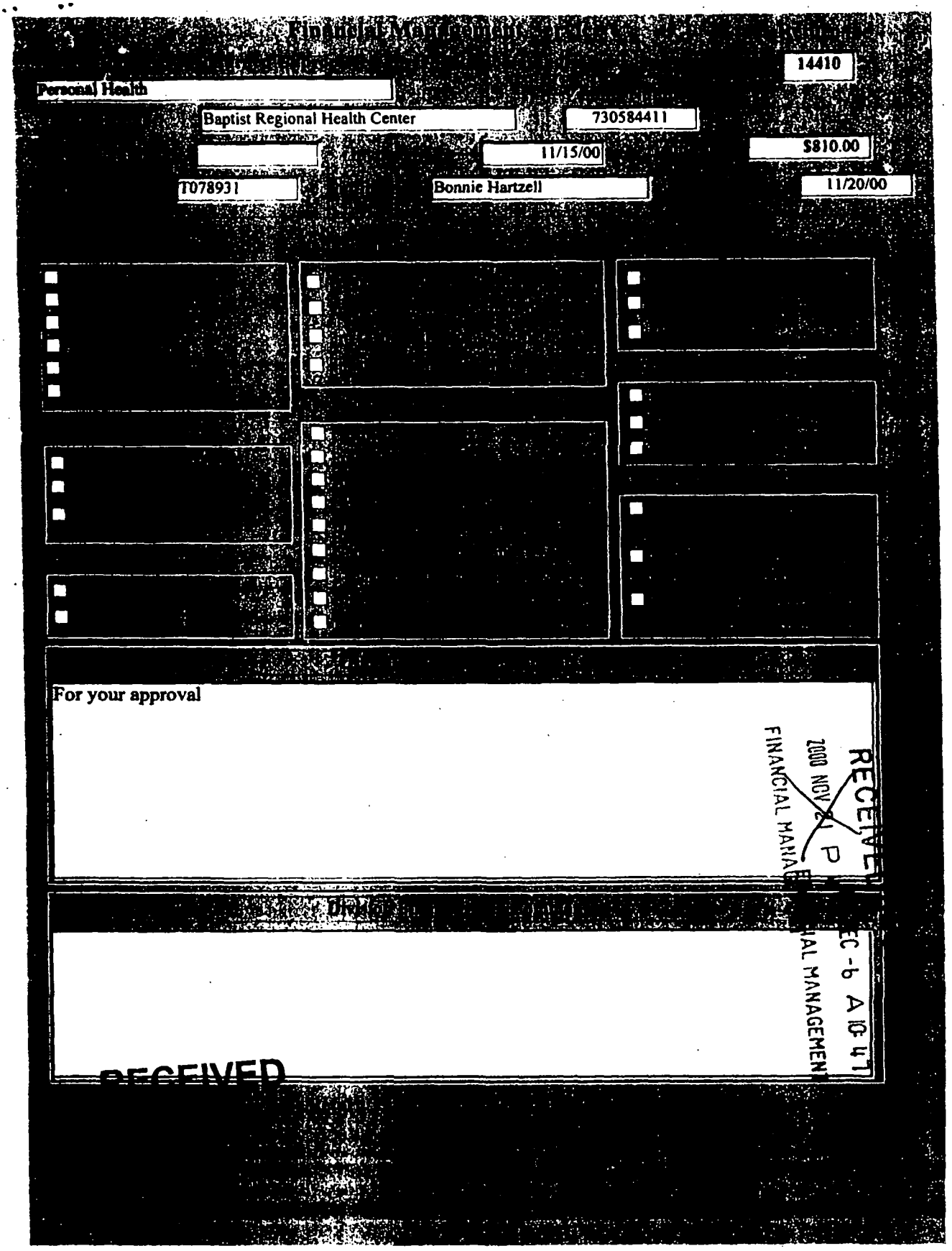
RECEIVED
NOV 2 2 2000
Personal Health Finance

If you have questions regarding this invoice please contact Dave Simpson at (918)540-7624.

Previous Balance

PLEASE PAY THIS AMOUNT $. 810.00

RECEIVED
2000 NOV 17 P 4: 23
FINANCIAL MANAGEMENT


14410
Personal Health
Baptist Regional Health Center
730584411
11/15/00
$810.00
T078931
Bonnie Hartzell
11/20/00
For your approval
RECEIVED
2000 NOV 21 P
FINANCIAL MANA
RECEIVED
EC -6 A 10:47
AL MANAGEMEN

Time And Effort Cost
Cost Accumulation Schedule

December 26, 2001
Prepared By

Grant Name: Conduct Site Spec. Activities
Grant Number U50 / ATU686520-03
Grant Period 09/29/2000 TO 09/28/2001
Program Code 391

==ProgCost==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200010	91.03	168.57	0.00	704.31
200011	96.92	149.59	0.00	791.19
200012	62.26	111.22	0.00	1,208.53
200101	46.72	99.21	0.00	966.48
200102	60.50	115.88	0.00	747.34
200103	91.94	139.66	0.00	696.20
200104	77.55	196.02	0.00	1,059.63
200105	40.49	96.36	0.00	431.55
200106	46.17	153.10	0.00	910.81
200107	40.93	76.26	0.00	315.10
200108	58.71	120.59	0.00	577.18
200109	172.31	134.24	0.00	537.33
Total	**885.53**	**1,560.70**	**0.00**	**8,945.65**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200010	11.98	22.18	0.00	92.69
200011	9.38	14.48	0.00	76.59
200012	8.22	14.69	0.00	159.63
200101	4.81	10.22	0.00	99.52
200102	6.24	11.96	0.00	77.10
200103	10.41	15.81	0.00	78.82
200104	8.29	20.98	0.00	113.32
200105	4.49	10.69	0.00	47.90
200106	5.42	17.96	0.00	106.82
200107	4.26	7.94	0.00	32.81
200108	5.89	12.10	0.00	57.94
200109	34.55	26.92	0.00	107.75
Total	**113.94**	**185.91**	**0.00**	**1,050.89**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
103.01	190.75	0.00	797.00
106.30	164.07	0.00	867.78
70.48	125.91	0.00	1,368.16
51.53	109.43	0.00	1,066.00
66.74	127.84	0.00	824.44
102.35	155.47	0.00	775.02
85.84	216.98	0.00	1,172.95
44.98	107.05	0.00	479.45
51.59	171.06	0.00	1,017.63
45.19	84.20	0.00	347.91
64.60	132.69	0.00	635.12
206.86	161.16	0.00	645.08
999.47	**1,746.61**	**0.00**	**9,996.54**

TRAVEL

9/29/2000 to 9/28/2001

Claims	4,751.19
PROGCOST - Travel	1,746.61
Total Travel	$ 6,497.80

Claims are the direct costs and PROGCOST are the allocated costs. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

Ottawa

OSF-Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		132482

FOR AGENCY USE: BT11 NW97 A-X

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	00013 5	42000	2111	93.200	96.26
NO XX			2114		2.38
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	98.64

FOR $ 98.64 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of H

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR DATE: 05/07/2001 WARR NUM: 8015492 CLAIM NO: 132482

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	4	6		8							
Miami-Vicinity-Miami	4	7		6							
Miami-Commerce-Vicinity-Miami	4	10	8	6							
Miami-Wyandotte-Vicinity-Miami	4	13		35							
Miami-Picher-Vicinity-Miami	4	16	20	4							
Miami-Picher-Vicinity-Miami	4	18	20	6							
Miami-Pryor-Vicinity-miami	4	19	104	6							
Miami-Quapaw-Vicinity-Miami	4	23	20	2							
Miami-quapaw-Vicinity-Miami	4	24	20	2							
Miami-Vicinity-Miami	4	26		6							
Miami-Vicinity-Miami	4	27		6							
TOTALS			192	87							
			279		279 TOTAL MILES @				34.5¢	PER MILE =	$96.26

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. [redacted]

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: 2.38	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 2.38
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	[redacted]
		TOTAL AMOUNT CLAIMED	$98.64

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 04-30 2001

My Commission expires ____ 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Administrator

Agency's Authorized Financial Management

Title

Agency, Bd., or Div. Use

MAY 03 2001

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA

OSF Form 19 - a
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		132483

FOR AGENCY USE: BT11 NW99 A-X

CLAIM OF: Nancy Horton

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	000133	482000	2111	93.200	240.12
NO XX			2114		13.40
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____	OSF - Audited By:			TOTAL AMOUNT	$253.52

FOR $ 253.52 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of He

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 0015493
WARR DATE: 05/07/2001

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	Lead - 391

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	4	3		10							
Miami-Fairland-Miami	4	6	22								
Miami-Vicinity-Miami	4	7		12							
Miami-Wyandotte-Vicinity-Miami	4	9		30							
Miami-Picher-Miami	4	10	20								
Miami-Picher-Miami	4	11	20								
Miami-Picher-Miami	4	16	20								
Miami-Oklahoma City-Miami	4	17	384								
Miami-Afton-Miami	4	19	30								
Miami-Afton-Miami	4	20	30								
Miami-Quapaw-Miami	4	23	20								
Miami-Quapaw-Vicinity-Miami	4	24	20	20							
TOTALS			566	130							
			696		696	TOTAL MILES @ 34.5¢			PER MILE =		$240.12

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. $240.12

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $13.40	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 13.40
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	$240.12
		TOTAL AMOUNT CLAIMED	$253.52

I, Nancy Horton, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 04-30 2001

My Commission expires _____, 19____

Susan Waldron
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Agency's Approving Officer

Chief, Financial Management

Title

OTTAWA COUNTY HEALTH DEPT.
Agency, Bd., or Div. Use

MAY 03 2001

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
	340		3453

FOR AGENCY USE

CLAIM OF: Nancy Horton

PERSONAL IDENTIFIER(S) REDACTED
S.S. No. _____

IS CAR GOV. OWNED?
YES _____
NO xx
LICENSE NO.

PERSONAL IDENTIFIER(S) REDACTED
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES xx
NO _____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
				1270

OSF - Audited By:

TOTAL AMOUNT $

FOR
$
AGAINST

Agency, Board,
Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

_____
Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Date Day	Mileage Claimed Map	Mileage Claimed Vicinity	Travel Status Hour Entered	Travel Status Hour Ended	No. of Days	No. of Hrs.	Per Diem Rate	Per Diem Amount	Lodging Amount	TOTAL PER DIEM LODGING
Miami-Vicinity-Miami	4	25		12								
Miami-Wyandotte-Vicinity-Miami	4	26		30								
Miami-Vicinity-Miami	4	27		18								

OSF Form 19 (Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		135832

FOR AGENCY USE: BT11 NW97 A-X

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ___ NO XX

License No. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00135	111005	211	93197020	38.30

OSF - Audited By: TOTAL AMOUNT $ 38.30

FOR $38.30 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to ___ and authorize the State Treasurer to issue warrant in payment to said assignee.

Date: ___

Claimant Signature

WARR DATE: 06/07/2001

WARR NUM: 8120180

CLAIM NO: 135832

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Wyandotte-Vic.-Miami	5	2		35							
Miami-Vicinity-Miami	5	3		8							
Miami-Vicinity-Miami	5	4		12							
Miami-Vicinity-Miami	5	5		8							
Miami-Picher-Vicinity-Miami	5	10	20	4							
Miami-Picher-Vicinity-Miami	5	18	20	4							
TOTALS			40	71							

111 — 111 TOTAL MILES @ 34 5¢ PER MILE = $38.30

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):
SHUTTLE:	TELEPHONE: TOLLS:
RENTAL CAR:	PARKING: TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP.

TOTAL AMOUNT CLAIMED $38.30

I, /Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron

Claimant Signature

State of OKLAHOMA County of OTTAWA

I hereby approve this claim for payment and certify it complies with the travel laws of the State. State Travel Reimbursement Act or

JUN 05 2001

Agency's Approval: Chief Financial Management

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		135859

FOR AGENCY USE: BT11 NW 97 A-X

CLAIM OF: Nancy Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2111	93200000	31.05

IS CAR GOV. OWNED? YES ____ NO xx

PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES xx NO ____

OSF - Audited By:

TOTAL AMOUNT $ 31.05

FOR $31.05 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 8120197
WARR DATE: 06/07/2001
135859

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	5	3		10							
Miami-Vicinity-Miami	5	4		12							
Miami-Vicinity-miami	5	5		6							
Miami-Picher-Vicinity-Miami	5	10	20	16							
Miami-Picher-Vicinity-miami	5	11	20								
Miami-Vicinity-Miami	5	31		6							
TOTALS			40	50							
			90		90	TOTAL MILES @ 34.5¢			PER MILE =		$31.05

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $31.05

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 5-31 2001

My Commission expires ____ 19__

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Officer

Chief Financial Management

JUN 05 2001

OTTAWA CO

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
100	340		113835 pr

FOR AGENCY USE: BT 11 NW 97 01746

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MX 11/2002

FOR $261.93 **AGAINST**

Agency, Board, Comm., Dept.: Okla. State Dept. of

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	00035	42000	2111	93.200000	247.33
NO XX			2114		14.60
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES XX					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT	$261.93

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Exited	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Commerce-Vicinity-Miami	10	3	8	2							
Miami-Vinita-Tulsa-Miami	10	5	181								
Miami-Vinita-Miami	10	6	54								
Miami-Commerce-Vicinity-Miami	10	10	8	2							
Miami-Oklahoma City-Miami	10	13	384								
Miami-Wyandotte-Vicinity-Miami	10	14		35							
Miami-Commerce-Vicinity-Miami	10	17	8	2							
Miami-Wyandotte-Vicinity-Miami	10	18		35							
Miami-Commerce-Vicinity-Miami	10	30	8	6							
Miami-Picher-Vicinity-Miami	10	31	20	8							
TOTALS			671 90								
			761		761	TOTAL MILES @	32.5¢		PER MILE =		$247.33

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. $247.33

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $14.60	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 14.60
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	$247.33
		TOTAL AMOUNT CLAIMED	$261.93

I, Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, that full according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 10-31, 2000

My Commission expires _____, 19___

Jane Ann Tuka
Notary Public (or Clerk or Judge)

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

NOV 06 2000

R. C.
Agency's Approving Officer, Chief Financial Management

Title

OTTAWA COUNTY HEALTH DEPT.
Agency, Bd., or Div. Use 1930 NORTH ELM
MIAMI, OK 74354

CLAIM NO: 113835

CHECK NO: 440013

CHECK DATE: 11/15/2000

Ottawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		1171118

FOR AGENCY USE: BT11 NW97 D1174B

CLAIM OF: susan waldron

PERSONAL IDENTIFIER(S) REDACTED

S.S. No. _____

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2111	93.200000	240.83
		2112		75.00
		2114		12.80
		2115		120.00

OSF - Audited By:

TOTAL AMOUNT $ 448.63

FOR $ 448.63 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

ASSIGNMENT
I hereby assign this claim to _____

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date: _____

Claimant Signature

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - LEAD GRANT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount	
Miami-Picher-Vicinity-Miami	11	8	20	4								
Miami-Commerce-Vicinity-Miami	11	9	8	2								
Miami-Picher-Vicinity-Miami	11	9	20	4								
Miami-Norman	11	14	208		20:00						~~$44.64~~	
Norman	11	15								~~$25.00~~	~~$44.64~~	~~$69.64~~
Norman	11	16								~~$25.00~~	~~$44.64~~	~~$69.64~~
Norman-OK City-Vicinity-Miami	11	17	208	33		20:00	1	—	25	~~$25.00~~ 75.00	120.00	~~$25.00~~
Miami-Vicinity-Miami	11	21		8								
Miami-Tulsa-Miami	11	22	178									
Miami-Picher-Vicinity-Miami	11	28	20	4								
Miami-Picher-Vicinity-Miami	11	30	20	4								
TOTALS			682	59								$208.92
			741		741	TOTAL MILES @			32.5¢		PER MILE =	$240.83

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $449.75

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $12.80	
RENTAL CAR:	PARKING:	TOTAL MISC.	$12.80
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	~~$449.75~~
		TOTAL AMOUNT CLAIMED	~~$462.55~~ 448.63

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 10-05 2000

My Commission expires _____ 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or _____

DEC 14 2000

Agency's Approving Officer

Chief, Financial Management

Title OTTAWA COUNTY HEALTH DEPT.

Agency, Bd., or Div Use 1930 NORTH ELM
MIAMI OKLAHOMA 74354

FAIRFIELD INN

Page: 1
Date: 11/17/00

NORMAN FAIRFIELD INN
301 NORMAN CENTER CT
NORMAN, OK 73072
405-447-1661

Arrival: 11/14/00
Departure: 11/17/00

Guest Name: WALDRON, SUSAN
Address:

Mbr. ID:
Level:

Room: 301
Folio Id: 16514 - 2ZX
Plan: REGA

Date	Description	Reference	Charges	Credits	Balance
11/14/00	Regular Room Charge	Room 301	$40.00	$0.00	$40.00
11/14/00	Occupancy Tax	Room 301	$1.60	$0.00	$41.60
11/14/00	State Tax	Room 301	$3.04	$0.00	$44.64
11/15/00	Regular Room Charge	Room 301	$40.00	$0.00	$84.64
11/15/00	Occupancy Tax	Room 301	$1.60	$0.00	$86.24
11/15/00	State Tax	Room 301	$3.04	$0.00	$89.28
11/16/00	Regular Room Charge	Room 301	$40.00	$0.00	$129.28
11/16/00	Occupancy Tax	Room 301	$1.60	$0.00	$130.88
11/16/00	State Tax	Room 301	$3.04	$0.00	$133.92
11/17/00	Visa	KLR THANK YOU	$0.00	-$133.92	$0.00

NORMAN FAIRFIELD #167
301 NORMAN CENTER COURT
NORMAN, OK. 73072
405-447-1661

MERCHANT ID: 1301512886095
DATE: 11/17/00 7:30:01 AM

* CHECK OUT *

RECORD NUMBER: 00008
ROOM #: 301
ACCOUNT: PERSONAL IDENTIFIER(S) REDACTED
CARD TYPE: VISA
TRAN TYPE: CHECK OUT
CHECK IN DATE: 11/14/00
CHECK OUT DATE: 11/17/00
AUTH CODE: 434357

TRAN TYPE	AUTH CODE	TRAN AMOUNT	TRAN DATE
SKIN	434357	12.00	111700
INCR	448025	121.92	111700

TOTAL APPROVED: 2 ITEMS 133.92

FINAL AMOUNT: 133.92

X Susan A. Waldron

I AGREE TO PAY THE ABOVE AMOUNT
ACCORDING TO CARD ISSUER AGREEMENT.
PLEASE IMPRINT CARD

TOP COPY MERCHANT
BOTTOM COPY TO CUSTOMER

$0.00

X _____

Cardholder acknowledges receipt of goods and/or services in the amount of the total shown above and agrees to perform the obligations and terms in the cardholder agreement with the seller.

OKLAHOMA PUBLIC HEALTH LEADERSHIP INSTITUTE

November 15, 16, & 17, 2000
OU/DHS TRAINING CENTER
Norman, Oklahoma

MODULE 3

Leadership in Political and Social Change,
Leadership for Public Health Policy and Practice,
Providing Leadership: Applying Theory to Practice

OBJECTIVES AND COMPETENCIES

1. **Develop skills for being an advocate for public health.**
   - Improve the health status of various "communities" through participation in the development of public policy.
   - Identify strategies to inform the community and key individuals about state and community health issues.

2. **Increase communication skills.**
   - Understand and apply public health marketing concepts.
   - Learn how to improve the credibility of public health in the community.

3. **Demonstrate an understanding of the community planning process through the development and presentation of a team project.**

OKLAHOMA PUBLIC HEALTH LEADERSHIP INSTITUTE

November 15, 16, & 17, 2000
OU/DHS TRANING CENTER
Norman, Oklahoma

MODULE 3

Leadership in Political and Social Change,
Leadership for Public Health Policy and Practice,
Providing Leadership: Applying Theory to Practice

Wednesday, November 15, 2000

8:30	**Working with the Legislature** **Presenters:** *Oklahoma State Senator Ben Brown* And *Oklahoma State Senator Angela Monson*
12:00	**Lunch**
1:00-4:00	**Communicating Health / Working with the Media** **Presenter:** *Leslea Bennett-Webb, MPH,* *Director, Office of Communications, OSDH* Mrs. Bennett-Webb will be presenting a bit of history about the OSDH Communications Department and will be sharing how this department is here to help you. Participants will also learn techniques for working with the media.
4:00-4:30	**Wrap up, Evaluation, Adjourn**

OKLAHOMA PUBLIC HEALTH LEADERSHIP INSTITUTE

November 15, 16, & 17, 2000
OU/DHS TRAINING CENTER
Norman, Oklahoma

MODULE 3

Leadership in Political and Social Change,
Leadership for Public Health Policy and Practice,
Providing Leadership: Applying Theory to Practice

Thursday, November 16, 2000

8:30	**Visit with Mr. Jerry Regier** Acting Director, Department of Health, Secretary of Health and Human Services
9:30	**Break**
10:00	**Turning Point** ***Presenter**: Valerie Williams,* *Associate Dean, Interdisciplinary and Special Programs,* *College of Medicine, OU Health Sciences Center* Ms. Williams serves as Vice-Chair for the Oklahoma Turning Point Initiative. She will share with OPHLI Fellows some history about Turning Point, what future plans they have and how we can get involved. OPHLI alumni will share some of the ways they have been able to use what they learned from their participation in OPHLI.
12:00	**Lunch**
1:00	**Teams Work on Project**

OKLAHOMA PUBLIC HEALTH LEADERSHIP INSTITUTE

November 15, 16, & 17, 2000
OU/DHS TRAINING CENTER
Norman, Oklahoma

MODULE 3

Leadership in Political and Social Change,
Leadership for Public Health Policy and Practice,
Providing Leadership: Applying Theory to Practice

Friday, November 17, 2000

8:00	**Teams Present Case Study to a Panel of Judges**
12:00	**Lunch**
1:00-3:00	**Tying It All Together**
	Panel:
	Jon Cameron, Deputy Commissioner *Operations and Management*
	Sara DePersio, MD, MPH, Deputy Commissioner, *Personal Health Services*
	Steve Ronck, Acting Deputy Commissioner, *Local Health Services*
	Robert D. Vincent, Ph.D., Deputy Commissioner, *Health Promotion and Policy Analysis*
	Peggy Wiebener, Acting Deputy Commissioner, *Special Health Services*
	The panel will conduct an interactive discussion with participants. The panel members will share their views about the role that county and state health departments play in the future of public health and how OPHLI Fellows can be major players in carrying out the vision of OSDH.
3:00-3:30	**Wrap-up, Evaluation, Adjourn**

OHawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		119567

FOR AGENCY USE: BT11 NW97 01174B

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 1/3/01

FOR $ 13.92 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____ NO X	00135	92000	2115	93.200	13.92

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

OSF - Audited By:

TOTAL AMOUNT $ 13.92

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: 391 - LEAD PROJECT GRANT

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

MARK HUNT 7018007

DATE: 01/12/2001

CLAIM NO: 119567

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
~~SUPPLEMENTAL TO NOV.00, TRAVEL CLAIM#117668~~											
	11	14									4.6
	11	15									4.6
	11	16									4.7
TOTALS					TOTAL MILES @				PER MILE =		13.92

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

SEE COPY OF LETTER ATTACHED STATING NORMAN FAIRFIELD INN @ 44.64

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):
SHUTTLE:	TELEPHONE: TOLLS:
RENTAL CAR:	PARKING: TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP.
	TOTAL AMOUNT CLAIMED 13.92

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 12-29-00, 19____

My Commission expires _____, 19____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Appointed Officer, Agency Head or Designee

R. C. [illegible]

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT
1030 NORTH ELM
MIAMI, OKLAHOMA 74354

Date JAN 08 2001

November 15, 2000

Memorandum

From: Diane Biard–Holmes, Chief,
Human Resources Management Division

Subject: OPHLI Conference

The 2000 Oklahoma Public Health Leadership Institute has been scheduled as follows:

Date and time: November 15, 2000 (8:00 AM to 4:30PM)
November 16, 2000 (8:00 AM to 4:30PM)
November 17, 2000 (8:00 AM to 4:30PM)

Place: OU/DHS Training Center, Norman, OK

Designated Motel: Norman Fairfield Inn
301 Norman Center Court
Norman, OK 73072
Phone/Fax: (405) 447-1661

Room Rate: $40.00 plus $4.64 tax = $44.64

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

Ottawa.

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		11711

FOR AGENCY USE: BT 11 NW92 DIFAB

CLAIM OF: susan waldron

S.S. No. ~~PERSONAL IDENTIFIER(S) REDACTED~~

FOR $ 448.63 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	42100	3111	93.200000	240.83
NO XX			2112		75.00
			2114		12.80
			2115		120.00

LICENSE NO. ~~PERSONAL IDENTIFIER(S) REDACTED~~

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

OSF - Audited By: TOTAL AMOUNT $ 448.63

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - LEAD GRANT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	
Miami-Picher-Vicinity-Miami	11	8	20	4								
Miami-Commerce-Vicinity-Miami	11	9	8	2								
Miami-Picher-Vicinity-Miami	11	9	20	4								
Miami-Norman	11	14	208		20:00						~~$44.64~~	
~~Norman~~	11	15					0			~~$25.00~~	~~$44.64~~	~~$69.64~~
~~Norman~~	11	16					0			~~$25.00~~	~~$44.64~~	~~$69.64~~
Norman-OK City-Vicinity-Miami	11	17	208	33		20:00	1	—	25	~~$25.00~~ 75.00	120.00	~~$25.00~~
Miami-Vicinity-Miami	11	21		8								
~~Miami~~ Tulsa-Miami	11	22	178									
Miami-Picher-Vicinity-Miami	11	28	20	4								
Miami-Picher-Vicinity-Miami	11	30	20	4								
TOTALS			682	59								$208.92
			741		741	TOTAL MILES @	32.5¢		PER MILE =			$240.83

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $449.75

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS: $12.80	
RENTAL CAR:	PARKING:	TOTAL MISC. $12.80
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP. ~~$449.75~~
		TOTAL AMOUNT CLAIMED ~~$462.55~~ 448.63

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 10-05 2000

My Commission expires _____, 19____

Notary Public (or Clerk or Judge)

Assembler Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Agency's Approving Officer DEC 14 20

Chief, Financial Management
Title

OTTAWA COUNTY HEALTH DEPT.
Agency, Bd., or Div. Use 1930 NORTH ELM
MIAMI, OKLAHOMA

NORMAN FAIRFIELD INN
301 NORMAN CENTER CT
NORMAN, OK 73072
405-447-1661

Arrival: 11/14/00
Departure: 11/17/00

Guest Name: WALDRON, SUSAN
Address:

Mbr. ID:
Level:

Room: 301
Folio Id: 16514 - 2ZX
Plan: REGA

Date	Description	Reference	Charges	Credits	Balance
11/14/00	Regular Room Charge	Room 301	$40.00	$0.00	$40.00
11/14/00	Occupancy Tax	Room 301	$1.60	$0.00	$41.60
11/14/00	State Tax	Room 301	$3.04	$0.00	$44.64
11/15/00	Regular Room Charge	Room 301	$40.00	$0.00	$84.64
11/15/00	Occupancy Tax	Room 301	$1.60	$0.00	$86.24
11/15/00	State Tax	Room 301	$3.04	$0.00	$89.28
11/16/00	Regular Room Charge	Room 301	$40.00	$0.00	$129.28
11/16/00	Occupancy Tax	Room 301	$1.60	$0.00	$130.88
11/16/00	State Tax	Room 301	$3.04	$0.00	$133.92
11/17/00	Visa	KLR THANK YOU	$0.00	-$133.92	$0.00

NORMAN FAIRFIELD #167
581 NORMAN CENTER COURT
NORMAN, OK. 73072
405-447-1661

MERCHANT ID: 1361512886075
DATE: 11/17/00 7:30:01 AM

* CHECK OUT *

RECORD NUMBER: 00000
ROOM #: 301
ACCOUNT: PERSONAL IDENTIFIER(S) REDACTED
CARD TYPE: VISA
TRAN TYPE: CHECK OUT
CHECK IN DATE: 11/14/00
CHECK OUT DATE: 11/17/00
AUTH CODE: 434357

TRAN TYPE	AUTH CODE	TRAN AMOUNT	TRAN DATE
----	------	------	------
CHTN	434357	12.00	111700
THCR	448825	121.92	111700

TOTAL APPROVED: 2 ITEMS 133.92

FINAL AMOUNT: 133.92

X _____
I AGREE TO PAY THE ABOVE AMOUNT
ACCORDING TO CARD ISSUER AGREEMENT.
PLEASE IMPRINT CARD

TOP COPY MERCHANT
BOTTOM COPY TO CUSTOMER

$0.00

X _____
Cardholder acknowledges receipt of goods and/or services in the amount of the total shown above and agrees to perform the obligations and terms in the cardholder agreement with the seller.

OHawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		119661

FOR AGENCY USE: BT11 NW97 011748

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 1/3/01

FOR $ 15.60 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

IS CAR GOV. OWNED? YES ___ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2111	93.200 -	15.60

OSF - Audited By:

TOTAL AMOUNT $ 15.60

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARRANT

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: 391 - LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI-PICHER-MIAMI	12	05	20	04							
MIAMI-PICHER-MIAMI	12	05	20	04							
TOTALS			40	08							
				48	TOTAL MILES @ .325				PER MILE =		15.60

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 15.60

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 12-29-00, 19 ___

My Commission expires _____, 19 ___

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act of _____

Agency's Approving Officer

Title

Agency, Bd., or Div Use

Chief Financial Management

JAN 08 2001
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

CLAIM NO: 119661
WARR NUM: 7618761
WARR DATE: 01/10/2001

Ottawa

OSF Form 197
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		119697

FOR AGENCY USE: BT11 NW97 01174B

CLAIM OF: SUSAN WALDRON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 1/3/01

FOR $606.43 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of I

IS CAR GOV. OWNED? YES ___ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	40000	2121	93.200 —	57.85
		2123		117.00
		2124		3.00
		2125		4.50
		2126		424.08

OSF - Audited By:

TOTAL AMOUNT $606.43

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7018795
WARR DATE: 01/10/2001
CLAIM NO: 119697

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: 391-LEAD PROJECT - OUT OF STATE TRAVEL-ATLANTA

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	
MIAMI-TULSA (AIRPORT) **	12	10	89		6:00AM							
ATLANTA XXXXXXXX-MARRIOTT MARQUIS											106.02	
ATLANTA -MARRIOTT MARQUIS	12	11					1		26.	26.00	106.02	
ATLANTA-MARRIOTT MARQUIS	12	12					1		26	26.00	106.02	
ATLANTA MARRIOTT MARQUIS	12	13					1		26	26.00	106.02	
TLANTA MARQUIS - TULSA_MIAMI	12	14	89			7:00PM	1	13	26	39.00		39.00
** AIRTRAVEL PRE-PAID BY OSDH												
TOTALS			178							117.00	424.08	541.08
					178 TOTAL MILES @ .325					PER MILE =		57.85

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE X (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS:	4.50
RENTAL CAR:	PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	3.00*
		TOTAL AMOUNT CLAIMED	606.43

*MARTA SUBWAY FROM ATLANTA AIRPORT TO HOTEL $1.50 = 3.00 EACH WAY (MUCH CHEAPER THAN CAB)

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 12-29-00, 19__

My Commission expires _____, 19__

Notary Public (or Clerk or Judge)

Jane Ann Nichols
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Officer

Title

Agency, Bd., or Div. Use

Chief, Financial Management JAN 08 2001
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Marriott
HOTELS · RESORTS · SUITES

ATLANTA MARRIOTT MARQUIS — GUEST FOLIO

419 WALDRON/SUSAN — 93.00 — 12/14/00 — 10:07 — 15419 — 6956
ROOM NAME — RATE — DEPART — TIME — ACCT# — GROUP

NSK — 12/10/00 — 14:01
TYPE — ARRIVE — TIME

7 PERSONAL IDENTIFIER(S) REDACTED

RC
CL..... /4343 — PERSONAL IDENTIFIER(S) REDACTED — /0701
ADDRESS — PAYMENT — MR#:

DATE	REFERENCE	CHARGES	CREDITS	BALANCE DUE
~~12/10 MOVIES~~	~~MOVIE~~	~~9.62~~		
12/10 ROOM	419, 1	93.00	-9.62	
12/10 STATE TX	419, 1	6.51	-.75	
12/10 CITY TAX	419, 1	6.51	-17.94	
12/11 ROOM	419, 1	93.00	-2.25	
12/11 STATE TX	419, 1	6.51		
12/11 CITY TAX	419, 1	6.51		
12/12 ROOM	419, 1	93.00		
12/12 STATE TX	419, 1	6.51		
12/12 CITY TAX	419, 1	6.51		
12/12 LOCAL				
~~1 @~~	~~.75~~	~~.75~~		
~~12/13 RM SERV~~	~~2559 419~~	~~17.94~~		
12/13 ROOM	419, 1	93.00		
12/13 STATE TX	419, 1	6.51		
12/13 CITY TAX	419, 1	6.51		
12/13 LOCAL				
~~3 @~~	~~.75~~	~~2.25~~		
12/14 CCARD-BK			454.64	

PAYMENT RECEIVED BY

PERSONAL IDENTIFIER(S) REDACTED .00

454.64
-30.56 (see above deletions)
424.08

Marriott
HOTELS · RESORTS · SUITES

This statement is your only receipt. You have agreed to pay in cash or by approved personal check or to authorize us to charge your credit card for all amounts charged to you. The amount shown in the credits column opposite any credit card entry in the reference column above will be charged to the credit card number set forth above. (The credit card company will bill in the usual manner.) If for any reason the credit card company does not make payment on this account, you will owe us such amount. If you are direct billed, in the event payment is not made within 25 days after check-out, you will owe us interest from the check-out date on any unpaid amount at the rate of 1.5% per month (ANNUAL RATE 18%), or the maximum allowed by law, plus the reasonable cost of collection, including attorney fees.

6-2855
Rev. 4/00

For Reservations At Any Marriott Hotel Call 1-800-228-9290
To enroll in Marriott Rewards call 1-800-249-0800

THIS ITEM PRINTED ON RECYCLED P

2nd NATIONAL LEAD GRANTEE CONFERENCE

Eliminating Childhood Lead Poisoning: Our Challenge for the Decade

CONFERENCE AGENDA

Atlanta Marriott Marquis
Atlanta, Georgia

December 11 - 13, 2000

Conference At-A-Glance

(See Back Pocket for Agenda Topics Overview)

Sunday, December 10, 2000

6:00 pm – 9:00 pm	Registration/Information (Convention Level)

Monday, December 11, 2000

7:30 am – 5:30 pm	Registration/Information (Convention Level)
8:30 am – 10:30 am	**Welcome and Plenary Session I**— Imperial Ballroom Salon B
10:30 am – 11:00 am	BREAK
11:00 am – 12:30 pm	**Concurrent Sessions A** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
12:30 pm - 2:00 pm	LUNCH (on your own)
2:00 pm - 3:30 pm	**Concurrent Sessions B** - Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
3:30 pm - 4:00 pm	BREAK
4:00 pm - 5:30 pm	**Concurrent Sessions C** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
5:30 pm - 7:00 pm	Exhibit/Poster Session – International Hall (North and South)

Tuesday, December 12, 2000

8:00 am – 5:30 pm	Registration/Information (Convention Level)
9:00 am – 10:30 am	**Plenary Session II**— Imperial Ballroom Salon B
10:30 am – 11:00 am	BREAK
11:00 am – 12:30 pm	**Concurrent Sessions D** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
12:30 pm - 2:00 pm	LUNCH (on your own)
2:00 pm - 3:30 pm	**Concurrent Sessions E** - Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
3:30 pm - 4:00 pm	BREAK
4:00 pm - 5:30 pm	**Concurrent Sessions F** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
5:30 pm - 7:00 pm	Exhibit/Poster Session – International Hall (North and South)

Wednesday, December 13, 2000

8:00 am – 12:30 pm	Registration/Information (Convention Level)
9:00 am - 10:30 am	**Concurrent Sessions G** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
10:30 am – 11:00 am	BREAK
11:00 am – 12:30 pm	**Plenary Session III**— Imperial Ballroom Salon B
12:30 pm	ADJOURN

General Information

Registration and Information
Registration is located on the **Convention Level** at Imperial Registration and will be open during the following hours:

Sunday, December 10th	**6:00pm - 9:00pm**
Monday, December 11th	**7:30am - 5:30pm**
Tuesday, December 12th	**8:00am - 5:30pm**
Wednesday December 13th	**8:00am - 12:30pm**

Conference Staff will be available during these hours to assist participants with registration, conference sessions, messages, social events, accommodations, dining, transportation, and any other special needs or questions. Messages for conference attendees will be posted on the message board in the registration area. Messages may be conveyed by calling the hotel at **(404) 521-0000** and requesting to be connected to the **2000 National Lead Grantee Conference Registration Desk.**

Conference Personnel
You may identify the following conference personnel according to the respective ribbons: **Conference staff - blue, Presenters - green, Moderators - red,** and **Exhibitors - turquoise.**

Exhibit/Poster Session
The Exhibit/Poster Session will be held on **Monday, December 11th**, and **Tuesday, December 12th**, from **5:30pm - 7:00pm** in the **International Hall (North and South)**

Speakers' Rehearsal Room
The **Copenhagen Room (Convention Level)** has been made available for presenters to preview and arrange their presentations. It will be open during registration hours (see *Registration and Information* above)

Workshop and Discussion Group Sessions
A total of 42 Workshop and 12 Discussion Group Sessions will be conducted during the conference. Although some sessions are designed to complement other sessions presented during the conference, **no session** will be repeated. Representatives from grantee organizations, in order to maximize the information received at the conference, should take this into account when planning session attendance. The discussion group sessions will run concurrently with the workshop sessions and are intended to be more interactive discussions on specific topics.

Special Sessions (Tuesday and Wednesday Morning 7:30am – 8:30am)
On **Tuesday, December 12th**, and **Wednesday, December 13th**, there may be special sessions convened to cover specific issues of interest not fully addressed at the conference. Information regarding these sessions will be included in your registration material or announced at the conference.

Rooms for Early Morning or Evening Meetings
Conference Rooms that will accommodate up to 150 people are available as needed. Please see conference logistical staff at the registration desk to reserve a room for an early morning or evening meeting.

Evaluation Forms
Evaluation Forms will be available for each workshop or discussion group session. Conference sponsors ask that all participants take a few minutes to fill out the evaluation form and leave it in the box at the back of the room. The overall conference evaluation is provided in your registration packet. Please complete this form and leave it with the staff in the **Registration Area** at end of the conference.

Remember that the hotel check-out time is 12:00 Noon!

2000 National Lead Grantee Conference

Eliminating Childhood Lead Poisoning: Our Challenge for the Decade

Agenda Sessions Overview

Room Location: Salon A | Salon B | Salon C | Salon E&F | Salon G&H | Madrid/Trinidad | Stockholm | Amsterdam

Monday, December 11, 2000

8:30 AM	Welcome and Opening Remarks - Imperial Ballroom								
9:00 AM	Keynote Presentation and Plenary Session 1 - Imperial Ballroom								
10:30 AM	Break								
11:00 AM	(A1) National Lead Education & Outreach Programs: News You Can Use	(A2) Healthy Homes Initiative	(A3) New Technologies for Blood and Environmental Lead Analysis	(A4) A National Perspective: Recommendations of the CDC Advisory Committee	(A5) HUD's New Lead-Based Paint Regulation (Section 1012 of Title X)	(A6) Treatment of Lead-Related Cognitive Impairment	(A7) Overcoming Barriers to Developing Comprehensive Statewide Surveillance		Concurrent Sessions Track A
12:30 PM	Lunch (on your own)								
2:00 PM	(B1) Mobilizing Neighborhood - Based Community Support	(B2) Controlling Lead Hazards in Soil	(B3) Field Methods for the Detection and Measurement of Lead	(B4) Screening: Part 1	(B5) Results of the National Evaluation of the LBP Hazard Control Grant Program: Part 1	(B6) EPA/HUD & DOJ Enforcement Initiative of the Lead-Based Paint Disclosure Rule	(B7) Alternatives to STELLAR	(B8) Healthy Homes: Injury Prevention	Concurrent Sessions Track B
3:30 PM	Break								
4:00 PM	(C1) Enhancing State and Local Programs	(C2) Weatherization Program Coordination	(C3) Laboratory Issues	(C4) Screening: Part 2	(C5) Integrating LHC with Rehabilitation	(C6) Baltimore Lead Initiative	(C7) Lead Poisoning Prevention in Rural America and Tribal Lands	(C8) Healthy Homes: Allergen Control-What Works	Concurrent Sessions Track C
5:30 PM	Poster and Exhibit Session - International Hall (North and South)								

Tuesday, December 12, 2000

9:00 AM	Plenary Session 2 - Imperial Ballroom								
10:30 AM	Break								
11:00 AM	(D1) Lead Litigation	(D2) Effectiveness of Low Level Hazard Control Interventions	(D3) Training & Certification Standards for Lead Abatement	(D4) An HHS Perspective on Working with Medicaid	(D5) Effectively Managing Programs	(D6) Effectively Using Program Data	(D7) Partnering with Community-Based Organizations		Concurrent Sessions Track D
12:30 PM	Lunch (on your own)								
2:00 PM	(E1) Managing Lead Hazard Control Costs	(E2) Effective Relocation Strategies	(E3) Media Perspectives on Lead Issues	(E4) Creating Partnerships for Success	E(5) Coordinating the Components of Case Management	(E6) Linking Data Across Programs	(E7) Integrating Lead Hazard Control With Other Community Efforts	(E8) The Efficacy of Alternative Dust-Lead Cleaning Methods	Concurrent Sessions Track E
3:30 PM	Break								
4:00 PM	(F1) Selecting a Cost- Effective Lead Hazard Control Strategy	(F2) Innovative Childhood Lead Poisoning Primary Prevention Strategies	(F3) EPA's Proposed Lead Renovation & Remodeling Rule	(F4) Measuring Program Success	(F5) Results of the National Evaluation of the LBP Hazard Control Grant Program:Part 2	(F6) Mapping and GIS Initiatives	(F7) Education & Outreach Programs to Reduce Environmental Hazards to Children	(F8) The National Survey of Lead and Allergens in Housing	Concurrent Sessions Track F
5:30 PM	Poster and Exhibit Session - International Hall (North and South)								

Wednesday, December 13, 2000

9:00 AM	(G1) Bringing Data Sharing Concepts Together	(G2) Training and Economic Opportunities for Residents	(G3) Leveraging Additional Financing for Lead Poisoning Prevention	(G4) Setting Research Priorities for the Decade	(G5) Provider Education and Outreach	(G6) Status of the Sampling Technician Training Course	(G7) Lead Dust in Carpets	(G8) Healthy Homes: Environmental Assessment	Concurrent Sessions Track G
10:30 AM	Break								
11:00 AM	Plenary Session 3 - Imperial Ballroom								
12:30 PM	Adjourn								

Exhibition Level: Salon A, B, C, E&F, G&H, Poster and Exhibit Area Convention Level: Imperial Ballroom, Madrid/Trinidad, Stockholm, and Amsterdam (Discussion Group Sessions - Shaded Area)

OTTAWA 02

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		123835

FOR AGENCY USE: BT 11 NW97 04748

CLAIM OF:

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ___ NO xx

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2111	932000000	173.19
		2112		35.00
		2114		13.00

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES xx NO ___

OSF - Audited By:

TOTAL AMOUNT $ 221.19

FOR $221.19 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept.

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7757801
WARR DATE: 02/14/2001
CLAIM NO: 123835

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Commerce-Vic.-Miami	1	8	8	2							
Miami-Oklahoma City-Vicinity	1	9	192	10	17:30						
Oklahoma City-Vic.-Miami	1	10	192	10		19:30	1	2	35	35.00	
Miami-Picher-Vicinity-Miami	1	18	20	4							
Miami-Commerce-Vicinity-Miami	1	22	8	2							
Miami-Picher-Vicinity-Miami	1	22	20	4							
Miami-Vicinity-Miami	1	23		6							
Miami-Picher-Vicinity-Miami	1	26	20	4							
TOTALS			460	42			1	2		35.00	$ 35.00
			502		502	TOTAL MILES @ 34.5¢				PER MILE =	$173.19

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

**Claiming per diem in lieu of subsistence - $24.00 w/ Policy

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. $208.19

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS: $13.00	
RENTAL CAR:	PARKING:	TOTAL MISC. $ 13.00
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP. $208.19
		TOTAL AMOUNT CLAIMED $221.19

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 2-5 2001

My Commission expires ___ 19__

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Officer Chief Financial Management FEB 12 20

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEP
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

Ottawa, K

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		129139M

FOR AGENCY USE: BT11 NW97 01174B

CLAIM OF: SUSAN WALDRON

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

MK 4/2/01

FOR $ 239.82 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. o

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issu warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR DATE: 04/09/2001 WARR NUM: 7910415 CLAIM NO: 129139

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____ NO XX	22135	40000	2111	93.000000	191 82
			2112		35 00
			2114		13 00
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____	OSF - Audited By:			TOTAL AMOUNT $	239 82

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391 - LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Fairland-Miami	3	6	22								
Miami-Picher-Vicinity-Miami	3	8	20	4							
Miami-Picher-Vicinity-Miami	3	13	20	4							
* Miami-Oklahoma City-Vicinity	3	14	192	18	17:00						
Oklahoma City-Vicinity-Miami	3	15	192	20		19:30	1	2½		$35.00	
Miami-Vicinity-Miami	3	26		6							
Miami-Grove-Vicinity-Miami	3	27	48	10							
TOTALS			494	62							$ 35.00
			556		556	TOTAL MILES @		34.5¢	PER MILE =		$191.82

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

* Claiming per diem in lieu of subsistence

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. ~~$226.82~~

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $13.00	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 13.00
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	~~$226.82~~
		TOTAL AMOUNT CLAIMED	$239.82

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 03-29 2001.

My Commission expires _____, 19___

_____
Notary Public (or Clerk or Judge)

_____
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act

_____
Agency's Appointed Officer, Financial Management

APR 04 2001

Title
Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		118189 cw

FOR AGENCY USE 12-18-00
BI OT BT11 NW 97

CLAIM OF:
NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

FOR
$ 50.05
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

IS CAR GOV. OWNED?
YES ____
NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES XX
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00035	42000	2111	9320000	50.05

OSF - Audited By:

TOTAL AMOUNT $ 50.05

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARRANT

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - LEAD

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Wyandotte-Picher-Vic.-Miami	11	2	20	58							
Miami-Vicinity-Miami	11	14		6							
Miami-Picher-Miami	11	16	20								
Miami-Picher-Vicinity-Miami	11	22	20	6							
Miami-Picher-Vicinity-Miami	11	28	20	4							
TOTALS			80	74							
			154		154	TOTAL MILES @			32.5¢	PER MILE =	$50.05

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $50.05

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 11-30 2000

My Commission expires _____, 19__

Susan Waldron
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or _____ DEC 2 0 2000

Chief, Financial Management
Agency Approving Officer

Title
Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA

FINANCIAL MANAGEMENT
TRAVEL CLAIM CORRECTION REQUEST

Please Return With Claim

Reject Number: 6383

Division: Personal Health

Employee: Horton (Last Name) Nancy (First Name) MI

Travel for the Month of: November

Claim Amount: 50.05

Please provide information indicated by check box(es) below.

AUTHORIZATION

- ☐ Signature of Claimant
- ☐ Supervisor Signature
- ☐ Notary Seal/Date
- ☐ Need Personnel Action Authorizing Travel:
- ☑ Verify Funding Information

Fund	X
Account	X
Sub-Act	X
Position #	
Other	

Please Complete The Following:

- ☐ Nature of Official Business Block
- ☐ Car-owned Question
- ☐ State Employee Question
- ☐ Justification for weekend or holiday Travel must be on face of claim
- ☐ Agency, Board, or Divisional title
- ☐ SSN or FEI #
- ☐ License #

RECEIVED
2000 DEC 18 P 1:19
FINANCIAL MANAGEMENT

TRAVEL

- ☐ Airline coach-rate comparison cost is required on face of claim for out-of-state travel by privately owned vehicle.
- ☐ Time Entered Travel Status Required
- ☐ Time Ended Travel Status Required
- ☐ Beginning & Ending Time(s) and Date(s) of meeting for which travel authorized must be shown on face of claim.
- ☐ Please show name of person with whom claimant rode.
- ☐ Please list all additional passengers.
- ☐ Please list name(s) of person(s) sharing room on face of claim.

RECEIVED
DEC 15 2000
Personal Health Finance

RECEIPTS

- ☐ Designated Hotel documentation required.
- ☐ Lodging receipt must be provided and must reflect single room rate.
- ☐ Dated Parking/TurnPike Receipt(s) Required.
- ☐ Registration receipt: Statement required on face of claim indicating number of meals included and amount or: "Meals Not Included".
- ☐ Please state on face of claim whether a registration fee is required and how paid.

MISCELLANEOUS

- ☐ Map Milage Required
- ☐ Amount Exceeds Allotment

Other Remarks & Comments:

MK Correct 12/15/00 Budget is still in effect.

Financial Management Reviewed By: Charles Lovell

12/12/00
Date:

OTTAWA CO

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		119935

FOR AGENCY USE: BT11 NW 97 01249Y

CLAIM OF: Nancy C. Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

Mr. 11/8/01

FOR $37.38 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
[illegible]	42000	2111	93200000	37.38

OSF - Audited By:

TOTAL AMOUNT $ 37.38

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date: _____

Claimant Signature

WARRANT

WARR NUM: 7034004

WARR DATE: 01/10/2001

CLAIM NO: 119935

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami, OK	391 Lead Project - PHN

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Picher-Vicinity-Miami	12	1	20	6							
Miami-Picher-Fairland-Miami	12	4	42	13							
Miami-Cardin-Miami	12	6		14							
Miami-Picher-Miami	12	20	20								
TOTALS			82	33							

115 TOTAL MILES @ 32.5 PER MILE = 37.38

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 37.38

I, Nancy C. Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 01-02- 2001

My Commission expires _____, 19__

Notary Public (or Clerk or Judge)

Susan Waldron

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approving Supervisor

Title

Agency, Bd., or Div. Use

Chief Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354
918-540-2481

JAN 09 2001

Ottawa

OSF Form 19 (Revised 7/96)

STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		120196

FOR AGENCY USE: BT 11 NW97 06249Y

CLAIM OF: Nancy C. Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 1/8/01

FOR $544.08 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2123	93.200000	117.00
		2124		3.00
		2126		424.08

OSF - Audited By:

TOTAL AMOUNT $ 544.08

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date:

Claimant Signature

WARR DATE: 01/10/2001

WARR NUM: 7034135

CLAIM NO: 120196

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami, OK	391 Lead Project- Out of State Travel-Atlanta

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	
Miami-Tulsa (Airport)**	12	10	*		6:00AM						106.	
Atlanta Marriott Marquis												
Atlanta- Marriott Marquis	12	11					1			26.00	106.	
Atlanta- Marriott Marquis	12	12					1			26.00	106.	
Atlanta - Marriott Marquis	12	13					1			26.00	106.	
Atlanta-Marquis Tulsa-Miami	12	14				6:30	1	13		[illegible]		39.00
*Rode to Tulsa with co-worker Susan WALDRON												
**Airtravel pre-paid by OSDH												
TOTALS										117.00	424.08	541.08
					TOTAL MILES @					PER MILE =		

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	3.00**
**Marta Subway from Atlanta Airport toHotel $1.50 each way much cheaper than cab		TOTAL AMOUNT CLAIMED	544.08

I, ____ the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton

Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 12-29-00, 19 ____

My Commission expires ____, 19 ____

Susan Waldron

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approval

Title Chief Financial Management

Agency, Bd., or Div. Ottawa County Health Dept.

1930 North Elm JAN 10 2001

Miami, Oklahoma 7...

918-540-24...

Marriott
HOTELS · RESORTS · SUITES

ATLANTA MARRIOTT MARQUIS — GUEST FOLIO

ROOM	NAME	RATE	DEPART	TIME	ACCT#	GROUP
418	HORTON/NANCY	93.00	12/14/00		15171	6956

NSK
TYPE PERSONAL IDENTIFIER(S) REDACTED
97
ROOM CLERK

ARRIVE 12/10/00 TIME 14:01

PASSPORT: PERSONAL IDENTIFIER(S) REDACTED

PAYMENT MR#:

ADDRESS

DATE	REFERENCE		CHARGES	CREDITS	BALANCE DUE
12/10	ROOM	418, 1	93.00		
12/10	STATE TX	418, 1	6.51		
12/10	CITY TAX	418, 1	6.51		
12/11	ROOM	418, 1	93.00		
12/11	STATE TX	418, 1	6.51		
12/11	CITY TAX	418, 1	6.51		
~~12/11~~	~~MOVIES~~	~~MOVIE~~	~~9.95~~		
12/12	ROOM	418, 1	93.00		
12/12	STATE TX	418, 1	6.51		
12/12	CITY TAX	418, 1	6.51		
12/13	ROOM	418, 1	93.00		
12/13	STATE TX	418, 1	6.51		
12/13	CITY TAX	418, 1	6.51		
12/14	BK CARD			$433.70	

TO BE SETTLED TO: CURRENT BALANCE .00

THANK YOU FOR CHOOSING THE ATLANTA MARRIOTT MARQUIS! TO EXPEDITE YOUR CHECK-OUT, PLEASE CALL THE FRONT DESK OR PRESS "MENU" ON YOUR TV REMOTE CONTROL TO ACCESS VIDEO CHECK-OUT.

Marriott
HOTELS · RESORTS · SUITES

This statement is your only receipt. You have agreed to pay in cash or by approved personal check or to authorize us to charge your credit card for all amounts charged to you. The amount shown in the credits column opposite any credit card entry in the reference column above will be charged to the credit card number set forth above. [The credit card company will bill in the usual manner.] If for any reason the credit card company does not make payment on this account, you will owe us such amount. If you are direct billed, in the event payment is not made within 25 days after check-out, you will owe us interest from the check-out date on any unpaid amount at the rate of 1.5% per month (ANNUAL RATE 18%), or the maximum allowed by law, plus the reasonable cost of collection, including attorney fees.

6-6995

For Reservations At Any Marriott Hotel Call 1-800-228-9290

NATIONAL

.EAD GRANTEE CONFERENCE

Eliminating Childhood Lead Poisoning: Our Challenge for the Decade

CONFERENCE AGENDA

.tlanta Marriott Marquis
.tlanta, Georgia

December 11 - 13, 2000

Conference At-A-Glance

(See Back Pocket for Agenda Topics Overview)

Sunday, December 10, 2000

6:00 pm – 9:00 pm	Registration/Information (Convention Level)

Monday, December 11, 2000

7:30 am – 5:30 pm	Registration/Information (Convention Level)
8:30 am – 10:30 am	**Welcome and Plenary Session I**— Imperial Ballroom Salon B
10:30 am – 11:00 am	BREAK
11:00 am – 12:30 pm	**Concurrent Sessions A** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
12:30 pm - 2:00 pm	LUNCH (on your own)
2:00 pm - 3:30 pm	**Concurrent Sessions B** - Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
3:30 pm - 4:00 pm	BREAK
4:00 pm - 5:30 pm	**Concurrent Sessions C** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
5:30 pm - 7:00 pm	Exhibit/Poster Session – International Hall (North and South)

Tuesday, December 12, 2000

8:00 am – 5:30 pm	Registration/Information (Convention Level)
9:00 am – 10:30 am	**Plenary Session II**— Imperial Ballroom Salon B
10:30 am – 11:00 am	BREAK
11:00 am – 12:30 pm	**Concurrent Sessions D** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
12:30 pm - 2:00 pm	LUNCH (on your own)
2:00 pm - 3:30 pm	**Concurrent Sessions E** - Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
3:30 pm - 4:00 pm	BREAK
4:00 pm - 5:30 pm	**Concurrent Sessions F** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
5:30 pm - 7:00 pm	Exhibit/Poster Session – International Hall (North and South)

Wednesday, December 13, 2000

8:00 am – 12:30 pm	Registration/Information (Convention Level)
9:00 am - 10:30 am	**Concurrent Sessions G** – Exhibition Level Salons: A, B, C, E&F, G&H Convention Level: Madrid/Trinidad, Stockholm, Amsterdam
10:30 am – 11:00 am	BREAK
11:00 am – 12:30 pm	**Plenary Session III**— Imperial Ballroom Salon B
12:30 pm	ADJOURN

General Information

Registration and Information

Registration is located on the **Convention Level** at **Imperial Registration** and will be open during the following hours:

Sunday, December 10th	**6:00pm - 9:00pm**
Monday, December 11th	**7:30am - 5:30pm**
Tuesday, December 12th	**8:00am - 5:30pm**
Wednesday December 13th	**8:00am - 12:30pm**

Conference Staff will be available during these hours to assist participants with registration, conference sessions, messages, social events, accommodations, dining, transportation, and any other special needs or questions. Messages for conference attendees will be posted on the message board in the registration area. Messages may be conveyed by calling the hotel at **(404) 521-0000** and requesting to be connected to the **2000 National Lead Grantee Conference Registration Desk.**

Conference Personnel

You may identify the following conference personnel according to the respective ribbons: **Conference staff - blue, Presenters - green, Moderators - red,** and **Exhibitors - turquoise.**

Exhibit/Poster Session

The Exhibit/Poster Session will be held on **Monday, December 11th**, *and* **Tuesday, December 12th**, *from* **5:30pm - 7:00pm** in the **International Hall (North and South)**

Speakers' Rehearsal Room

The **Copenhagen Room (Convention Level)** has been made available for presenters to preview and arrange their presentations. It will be open during registration hours (*see Registration and Information above*)

Workshop and Discussion Group Sessions

A total of 42 Workshop and 12 Discussion Group Sessions will be conducted during the conference. Although some sessions are designed to complement other sessions presented during the conference, **no session** will be repeated. Representatives from grantee organizations, in order to maximize the information received at the conference, should take this into account when planning session attendance. The discussion group sessions will run concurrently with the workshop sessions and are intended to be more interactive discussions on specific topics.

Special Sessions (Tuesday and Wednesday Morning 7:30am – 8:30am)

On **Tuesday, December 12th**, and **Wednesday, December 13th**, there may be special sessions convened to cover specific issues of interest not fully addressed at the conference. Information regarding these sessions will be included in your registration material or announced at the conference.

Rooms for Early Morning or Evening Meetings

Conference Rooms that will accommodate up to 150 people are available as needed. Please see conference logistical staff at the registration desk to reserve a room for an early morning or evening meeting.

Evaluation Forms

Evaluation Forms will be available for each workshop or discussion group session. Conference sponsors ask that all participants take a few minutes to fill out the evaluation form and leave it in the box at the back of the room. The overall conference evaluation is provided in your registration packet. Please complete this form and leave it with the staff in the **Registration Area** at end of the conference.

Remember that the

2000 National Lead Grantee Conference
Eliminating Childhood Lead Poisoning: Our Challenge for the Decade
Agenda Sessions Overview

Room Locations:	Salon A	Salon B	Salon C	Salon E&F	Salon G&H	Madrid/Trinidad	Stockholm	Amsterdam

Monday, December 11, 2000

8:30 AM	Welcome and Opening Remarks - Imperial Ballroom								
9:00 AM	Keynote Presentation and Plenary Session 1 - Imperial Ballroom								
10:30 AM	Break								
11:00 AM	(A1) National Lead Education & Outreach Programs: News You Can Use	(A2) Healthy Homes Initiative	(A3) New Technologies for Blood and Environmental Lead Analysis	(A4) A National Perspective: Recommendations of the CDC Advisory Committee	(A5) HUD's New Lead-Based Paint Regulation (Section 1012 of Title X)	(A6) Treatment of Lead-Related Cognitive Impairment	(A7) Overcoming Barriers to Developing Comprehensive Statewide Surveillance		Concurrent Sessions Track A
12:30 PM	Lunch (on your own)								
2:00 PM	(B1) Mobilizing Neighborhood - Based Community Support	(B2) Controlling Lead Hazards in Soil	(B3) Field Methods for the Detection and Measurement of Lead	(B4) Screening: Part 1	(B5) Results of the National Evaluation of the LBP Hazard Control Grant Program: Part 1	(B6) EPA/HUD & DOJ Enforcement Initiative of the Lead-Based Paint Disclosure Rule	(B7) Alternatives to STELLAR	(B8) Healthy Homes: Injury Prevention	Concurrent Sessions Track B
3:30 PM	Break								
4:00 PM	(C1) Enhancing State and Local Programs	(C2) Weatherization Program Coordination	(C3) Laboratory Issues	(C4) Screening: Part 2	(C5) Integrating LHC with Rehabilitation	(C6) Baltimore Lead Initiative	(C7) Lead Poisoning Prevention in Rural America and Tribal Lands	(C8) Healthy Homes: Allergen Control-What Works	Concurrent Sessions Track C
5:30 PM	Poster and Exhibit Session - International Hall (North and South)								

Tuesday, December 12, 2000

9:00 AM	Plenary Session 2 - Imperial Ballroom								
10:30 AM	Break								
11:00 AM	(D1) Lead Litigation	(D2) Effectiveness of Low Level Hazard Control Interventions	(D3) Training & Certification Standards for Lead Abatement	(D4) An HHS Perspective on Working with Medicaid	(D5) Effectively Managing Programs	(D6) Effectively Using Program Data	(D7) Partnering with Community-Based Organizations		Concurrent Sessions Track D
12:30 PM	Lunch (on your own)								
2:00 PM	(E1) Managing Lead Hazard Control Costs	(E2) Effective Relocation Strategies	(E3) Media Perspectives on Lead Issues	(E4) Creating Partnerships for Success	E(5) Coordinating the Components of Case Management	(E6) Linking Data Across Programs	(E7) Integrating Lead Hazard Control With Other Community Efforts	(E8) The Efficacy of Alternative Dust-Lead Cleaning Methods	Concurrent Sessions Track E
3:30 PM	Break								
4:00 PM	(F1) Selecting a Cost- Effective Lead Hazard Control Strategy	(F2) Innovative Childhood Lead Poisoning Primary Prevention Strategies	(F3) EPA's Proposed Lead Renovation & Remodeling Rule	(F4) Measuring Program Success	(F5) Results of the National Evaluation of the LBP Hazard Control Grant Program:Part 2	(F6) Mapping and GIS Initiatives	(F7) Education & Outreach Programs to Reduce Environmental Hazards to Children	(F8) The National Survey of Lead and Allergens in Housing	Concurrent Sessions Track F
5:30 PM	Poster and Exhibit Session - International Hall (North and South)								

Wednesday, December 13, 2000

:00 AM	(G1) Bringing Data Sharing Concepts Together	(G2) Training and Economic Opportunities for Residents	(G3) Leveraging Additional Financing for Lead Poisoning Prevention	(G4) Setting Research Priorities for the Decade	(G5) Provider Education and Outreach	(G6) Status of the Sampling Technician Training Course	(G7) Lead Dust in Carpets	(G8) Healthy Homes: Environmental Assessment	Concurrent Sessions Track G
	Break								
	Plenary Session 3 - Imperial Ballroom								
	Adjourn								

ot: Salon A, B, C, E&F, G&H, Poster and Exhibit Area Convention Level: Imperial Ballroom, Madrid/Trinidad, Stockholm, and Amsterdam (Discussion Group Sessions - Shaded Area)

Ottawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		126121 cw

FOR AGENCY USE
BT 11 NW97 01249

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

FOR $217.08 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

IS CAR GOV. OWNED? YES ____ NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES XX NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00013	43000	2111		205.28
		2114	93.200	11.80

OSF - Audited By: TOTAL AMOUNT $217.08

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant Signature

WARR NUM: 7023902
WARR DATE: 03/12/2001
CLAIM NO: 126121

OFFICIAL DUTY STATION: MIAMI

NATURE OF OFFICIAL BUSINESS: 391 - LEAD

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
MIAMI-Picher-Miami	2	1	20								
Miami-Picher-Miami	2	7	20								
Miami-Fairland-Miami-PIcher-Miami Vicinity-Miami	2	8	42	3							
Miami-Picher-Miami	2	12	20								
Miami-Oklahoma City-Miami	2	13	384								
Miami-Picher-Vicinity-Miami	2	15	20	20							
Miami-Vicinity-Miami	2	20		6							
Miami-Picher-Miami	2	21	20								
Miami-Picher-Miami	2	22	20								
Miami-Picher-Miami	2	23	20								
TOTALS			566	29							
			595		595	TOTAL MILES @	34.5¢		PER MILE =		$205.28

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $205.28

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: $11.80	
RENTAL CAR:	PARKING:	TOTAL MISC.	$ 11.80
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	$205.28
		TOTAL AMOUNT CLAIMED	$217.08

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 02-28 2001

My Commission expires _____ 19 ____

Susan Waldron
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or

Chief, Financial Management
Agency's Approving Officer

MAR 06 2001

Title

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354
Agency, Bd., or Div. Use

Ottawa mk

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
200	340		12820 mk

FOR AGENCY USE: B11 N097 01099

CLAIM OF: Nancy Horton

S.S. NO. PERSONAL IDENTIFIER(S) REDACTED mk 3/30/01

FOR $ 66.24 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to warrant in payment to said assignee
Date: _____
_____ Claimant Signature

BANK NUMBER 103900202
BANK NUMBER 1000000
CLAIM NUMBER 12820

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	200	1221	211	93.994	66.24
NO x					
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES x					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	66.24

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	Lead-301

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1901 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodg Amo
Miami-Picher-Miami	03	07	20								
Miami-Picher-Miami	03	08	20								
Miami-Picher-Miami	03	09	20	04							
Miami-Picher-Miami	03	12	20								
Miami Vicinity	03	22		06							
Miami-Picher-Miami Vicinity	03	26	20	42							
Miami-Picher-Miami	03	28	20	20							
TOTALS			120	72							
			192		TOTAL MILES @	.345			PER MILE =		66.24

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 66.24

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 3-29-01, 19 01.

My Commission expires _____, 19 ____

_____ Notary Public (or Clerk or Judge)

Susan Watkins
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

R. C. Hines
Chief Financial Management

Agency's Approving Official

Title

Agency, Bd., or Div. Use

OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM APR 02 2001
MIAMI, OKLAHOMA 74354

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X001821	115391

FOR AGENCY USE
WARRANT # 7490558 DATE: 11/27/2000

CLAIM OF:
TRAVEL AGENTS INC.
731270787

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2211	932000000	375.00

FOR
$ 375.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant:

WARRANT (LOCATOR NO.)

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
023		375.00

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001117

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/17/2000	48506	375.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 221110088X 375.00

J/E XREF:

VENDOR: TRAVEL AGENTS INC.
ADDRESS: 9415 NORTH MAY
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73120

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/21/2000

Title Date

Agency, Bd or Div. Use

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: 56 ITINERARY/INVOICE NO. 00468506 DATE: 17 NOV 00
CUSTOMER NBR: 012057 WSETEP PAGE: 01

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVISION
ORDERED BY MELISSA 271 1262
PURCHASE ORDER NUMBER X0010210

FOR: HORTON/NANCY REF:

PERSONAL IDENTIFIER(S) REDACTED

DELTA TICKETLESS CONFIRMATION NBR D9648F

10 DEC 00 - SUNDAY

AIR	DELTA AIR LINES INC	FLT:1556	COACH	
	LV TULSA		1000A	EQP: BOEING 727-200
				01HR 52MIN
	AR ATLANTA		1252P	NON-STOP
				REF: D9648F
	HORTON/NANCY	SEAT-19F		

14 DEC 00 - THURSDAY

AIR	DELTA AIR LINES INC	FLT:1481	COACH	
	LV ATLANTA		1155A	EQP: BOEING 727-200
				02HR 02MIN
	AR TULSA		1257P	NON-STOP
				REF: D9648F
	HORTON/NANCY	SEAT-12F		

AIR TICKET	DL7132298428	HORTON NANCY	375.00
ELEC TKT			
		SUB TOTAL	375.00
		TOTAL AMOUNT DUE	375.00

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES. ANY ERRORS SHOULD BE REPORTED TO US IMMEDIATELY
PAYMENT IS DUE UPON RECEIPT OF INVOICE

AG-66

RECEIVED
NOV - 2 2000
Financial Health Finance

PO X001821 W 10/03

731270787

2211100884

Control No.

Date 11-16-00

Budget Code Melissa 56223

OKLAHOMA STATE DEPARTMENT OF HEALTH

INTERSTATE TRAVEL REQUEST/AUTHORIZATION

Nancy Horton - Atlanta Ga 13/01

93.2100000

DIVISION: MCH-Screening & Special Services SSN PERSONAL IDENTIFIER(S) REDACTED

TO BE CHARGED TO: 400BT11 000135NW9700 42000 (Fund & Account) ____ % (State) 100 % (Federal)

APPLICANT: Nancy Horton POSITION (Title): Project Coordinator-Lead Poisoning Prevention Program

DATE OF DEPARTURE: 12/10/00

NATURE OF TRIP (School, Meeting, Convention, etc.): Conference

2000 National Lead Grantee Conference (Name) 12/10-13/00 (Date) Atlanta, GA (Location)

MODE OF TRAVEL (Private - Public): PUBLIC

ESTIMATED COST: $ 375.00 (Travel) Hotel 424.00 perdiem 180.00 (per diem) No Reg. Fee $ Taxi-25.00 (Other) $ 1004.00 (Total)

JUSTIFICATION FOR TRIP: AS Program Coordinator for the Lead Poisoning Prevention Program Ms. Horton has been as to attend this "by invitation only conference" for grant recepients. The 2000 National Grantee Conference is held once every two years and attendance at this conference is a budgeted item as directed by CDC. Funding for attendance at this conference is covered by ATSDR Cooperative Agreement Program to Build Capacity to Conduct Site-Specific Environmental Health Education and Monitoring Activities"

DURATION OF TRIP WILL INCLUDE 4 DAYS AT MEETING AND 1 DAYS ENROUTE.

TOTAL OF 5 DAYS.

APPROVED: (KC) Service or Office Chief/Division Director

APPROVAL AND TRAVEL AUTHORIZATION

The individual named herein is authorized to perform official travel as indicated.

Commissioner

11/13/00 Date

OSDH Form No. 81
(Rev. 8/78)

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X001821	118764

FOR AGENCY USE
WARRANT # 7591290 DATE: 01/02/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2211	932000000	11.00

CLAIM OF:
TRAVEL AGENTS INC.
731270787

1 1 8 7 6 4

FOR
$ 11.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
923		11.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001206

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/06/2000	48821	11.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 221110088X 11.00

J/E XREF:

VENDOR: TRAVEL AGENTS INC.
ADDRESS: 9415 NORTH MAY
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73120

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

12/28/2000

Title Date

Agency, Bd or Div. Use

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES REP#: [illegible] [illegible] DATE OF DEL: [illegible]
CUSTOMER #: [illegible] PAGE: #1

118764 MT

TO: STATE DEPT OF HEALTH -
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DROP TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVISION
ORDERED BY MELISSA 271 1262
PURCHASE ORDER NUMBER X98182IW

FOR: HORTON/NANCY REF PERSONAL IDENTIFIER(S) REDACTED

TWA : ELECTRONIC TICKET CONFIRMATION NBR 3APLPC

10 DEC 90 - SUNDAY
AIR TRANS WORLD AIRLINES FLT:5434 ECONOMY -
LV TULSA #85A EQP: MD-80
MILE 1sn IN
AR ST LOUIS/LAMBERT V21A NON-STOP
ARRIVE: MAIN TERMINAL RES: 3APLPI
HORTON/NANCY SEAT-27A
AIR TRANS WORLD AIRLINES FLT:5518 ECONOMY
LV ST LOUIS INTL 1151A EQP: MD-80
DEPART: MAIN TERMINAL MILE 35MIN
AR ATLANTA 1255P NON-STOP
RES: 3APLPI
HORTON/NANCY SEAT 16F

14 DEC 90 FRIDAY
AIR TRANS WORLD AIRLINES FLT:2569 ECONOMY
LV ATLANTA 1235P EQP: BOEING 727
MILE 49MIN
AR ST LOUIS/LAMBERT 1:24 NON-STOP
ARRIVE: MAIN TERMINAL RES: 3APLPI
HORTON/NANCY SEAT-27A
AIR TRANS WORLD AIRLINES FLT:5519 ECONOMY
LV ST LOUIS INTL 4:15P EQP: MD-80
DEPART: MAIN TERMINAL MILE 42MIN
AR TULSA 5:30P NON-STOP
RES: 3APLPI
HORTON/NANCY SEAT 16F

AIR TICKET TWA/[illegible] HORTON/NANCY 386.00
SEE (F)

SUB TOTAL 386.00

TOTAL AMOUNT DUE 386.00

Credit Memo #107564 (-375.00)

11.00 MT

NOTE...TAT IS NOT RESPONSIBLE FOR CHANGE FEES, AND ERRORS SHOULD BE REPORTED TO US IMMEDIATELY. PAYMENT IS DUE UPON RECEIPT OF INVOICE

CONTINUED ON PAGE 2

Ref# 118457

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS

PO X001821 W 10/03

Control No. _____
Date 11-16-00 mf
Budget Code _____
Melissa 56223

OKLAHOMA STATE DEPARTMENT OF HEALTH

INTERSTATE TRAVEL REQUEST/AUTHORIZATION

Nancy Horton - Atlanta Ga 130/01

93.20000000

ON: MCH-Screening & Special Services SS# PERSONAL IDENTIFIER(S) REDACTED

TO BE CHARGED TO: 400BT11 000135NW9700 42000 (Fund & Account) _____ % (State) 100 % (Federal)

APPLICANT: Nancy Horton POSITION (Title): Project Coordinator-Lead Poisonin Prevention Program

DATE OF DEPARTURE: 12/10/00

NATURE OF TRIP (School, Meeting, Convention, etc.): Conference

2000 National Lead Grantee Conference (Name) 12/10-13/00 (Date) Atlanta, GA (Location)

MODE OF TRAVEL (Private - Public): PUBLIC

REFUNDABLE

ESTIMATED COST: $ 375.00 (Travel) Hotel 424.00 $perdiem-180.00 (per diem) No Reg. Fee $ Taxi-25.00 (Other) $ 1004.00 (Total)

JUSTIFICATION FOR TRIP: AS Program Coordinator for the Lead Poisoning Prevention Program Ms. Horton has been as to attend this "by invitation only conference" for grant recepients. The 2000 National Grantee Conference is held once every two years and attendance at this conference is a budgeted item as directed by CDC. Funding for attendance at this conference is covered by ATSDR Cooperative Agreement Program to Build Capacity to Conduct Site-Specific Environmental Health Education and Monitoring Activities"

DURATION OF TRIP WILL INCLUDE 4 DAYS AT MEETING AND 1 DAYS ENROUTE.

TOTAL OF 5 DAYS.

APPROVED: SL [signature] Service or Office Chief/Division Director

KL

APPROVAL AND TRAVEL AUTHORIZATION

The individual named hereon is authorized to perform official travel as indicated.

[signature] Commissioner

11/13/00 Date

OSDH Form No. 81
(Rev. 8/78)

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: 66 ITINERARY/INVOICE NO. 0048821 DATE: 06 DEC 00
CUSTOMER NBR: 012057 WSEIEP PAGE: 01

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVSION
ORDERED BY MELISSA 271 1268
PURCHASE ORDER NUMBER X001821W 023
FOR: HORTON/NANCY REF: S PERSONAL IDENTIFIER(S) REDACTED

Cm# 107564 was only $375.00 - $11.00 due on this invoice

TWA TICKETLESS CONFIRMATION NBR 3APLNF

10 DEC 00 - SUNDAY

AIR	TRANS WORLD AIRLINES FLT:484	ECONOMY	
	LV TULSA	805A	EQP: MD-80
			01HR 16MIN
	AR ST LOUIS INTL	921A	NON-STOP
	ARRIVE: MAIN TERMINAL		REF: 3APLNF
	HORTON/NANCY SEAT-25A		
AIR	TRANS WORLD AIRLINES FLT:518	ECONOMY	
	LV ST LOUIS INTL	1016A	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 39MIN
	AR ATLANTA	1255P	NON-STOP
			REF: 3APLNF
	HORTON/NANCY SEAT-16F		

14 DEC 00 - THURSDAY

AIR	TRANS WORLD AIRLINES FLT:208	ECONOMY	
	LV ATLANTA	1235P	EQP: BOEING 717
			01HR 49MIN
	AR ST LOUIS INTL	124P	NON-STOP
	ARRIVE: MAIN TERMINAL		REF: 3APLNF
	HORTON/NANCY SEAT-22A		
AIR	TRANS WORLD AIRLINES FLT:511	ECONOMY	
	LV ST LOUIS INTL	215P	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 22MIN
	AR TULSA	337P	NON-STOP
			REF: 3APLNF
	HORTON/NANCY SEAT-27A		

AIR TICKET	TW7132298747	HORTON NANCY	386.00
ELEC TKT			
		SUB TOTAL	386.00
		TOTAL AMOUNT DUE	386.00

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES. ANY ERRORS SHOULD BE REPORTED TO US IMMEDIATELY
PAYMENT IS DUE UPON RECEIPT OF INVOICE

Credit 107564 (386.00)
-0-

~~CONTINUED ON PAGE 2~~

Zero Claim

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS.

TRAVEL AGENTS INCORPORATED

9415 NORTH MAY AVE.

OKLA CITY, OK 73120

2057 12 DEC 00 1 107564

CREDIT MEMO

STATE DEPT OF HEALTH
ATTN: DWIGHT BURLESON
P.O. BOX 53551
01 OKLA CITY, OK 73152

0
66

STATE DEPT OF HEALTH
ATTN: DWIGHT BURLESON
P.O. BOX 53551
OKLA CITY, OK 73152

AIRLINE	FL/CL	DATE	FROM	TO	LEAVE	ARRIVE
DELTA AIRLINES	1556Q	10DEC SUN	TULSA, OK	ATLANTA, GA	1000A	1252P
DELTA AIRLINES	1431Q	14DEC THU	ATLANTA, GA	TULSA, OK	1155A	1257P

HORTON/NANCY

TKT # 0067132298428 $ 375.00-

TKT REF, ORIG INV # 48506
ORIG. DATE OF ISSUE 17NOV

CREDIT MEMO TOTAL $ 375.00-

Posted to #48821

386.00

FULL REFUND
BF $ 338.60- TX $ 36.40- AC 01A6930- 107564

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X001821	118763

FOR AGENCY USE
WARRANT # 7591289 DATE: 01/02/2001

CLAIM OF:
TRAVEL AGENTS INC.
731270787

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	2211	931970000	11.00

FOR
$ 11.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant:

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
923		11.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001206

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/06/2000	48820	11.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 221110088X 11.00

J/E XREF:

VENDOR: TRAVEL AGENTS INC.
ADDRESS: 9415 NORTH MAY
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73120

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

12/28/2000
Date

Agency, Bd or Div. Use

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: ... ITINERARY/INVOICE NO. 00000000 DATE: 06 DEC 00
CUSTOMER REF: 0120** WSRJLP PAGE: 01

118763 ET

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
ATTN TO GWEN BURLESON 3RD FLOOR TRAVEL SYSTEM
APPROVED BY MELISSA **** ****
PURCHASE ORDER NUMBER A00186**

FOR: WALDRON/SUSAN REF PERSONAL IDENTIFIER(S) REDACTED

TWA TUESDAYS ONLY DEPARTURE NEW ORLEANS

10 DEC 00 - SUNDAY

AIR	TRANS WORLD AIRLINES FLT:0406	ECONOMY		
	LV TULSA	905A	EQP: MD-80	
			OTHR 1HR 1M	
	AR ST LOUIS INTL	721A	NON STOP	
	ARRIVE: MAIN TERMINAL		REF: SAPLNF	
	WALDRON/SUSAN SEAT-29A			
AIR	TRANS WORLD AIRLINES FLT:0518	ECONOMY		
	LV ST LOUIS INTL	1015A	EQP: MD-80	
	DEPART: MAIN TERMINAL		OTHR 35MIN	
	AR ATLANTA	1250P	NON-STOP	
			REF: SAPLNF	
	WALDRON/SUSAN SEAT-16A			

14 DEC 00 - THURSDAY

AIR	TRANS WORLD AIRLINES FLT:2098	ECONOMY		
	LV ATLANTA	1235P	EQP: BOEING 717	
			OTHR 49MIN	
	AR ST LOUIS INTL	134P	NON STOP	
	ARRIVE: MAIN TERMINAL		REF: SAPLNF	
	WALDRON/SUSAN SEAT-21A			
AIR	TRANS WORLD AIRLINES FLT:5511	ECONOMY		
	LV ST LOUIS INTL	235P	EQP: MD-80	
	DEPART: MAIN TERMINAL		OTHR 22MIN	
	AR TULSA	337P	NON-STOP	
			REF: SAPLNF	
	WALDRON/SUSAN SEAT-19A			

AIR TICKET	TW2152*****46	WALDRON SUSAN	366.00
SALES TAX			
		SUB TOTAL	366.00
		TOTAL AMOUNT DUE	366.00

NOTE... YOU ARE NOT RESPONSIBLE FOR CHANGE FEES. ALL ERRORS SHOULD BE REPORTED TO US IMMEDIATELY
PAYMENT IS DUE UPON RECEIPT OF INVOICE

credit memo #107563 375.00

Ref #11845/

11.00 MT

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS.

10/23

Control No. _____
Date 11-16-00 mf
Budget Code _____
Melissa 56223

...TATE DEPARTMENT OF HEALTH

...TRAVEL REQUEST/AUTHORIZATION

...Waldron - Atlanta Ga
133/01

...-Screening & Special Services SS# PERSONAL IDENTIFIER(S) REDACTED

...RGED TO: 400 BT11 000135 NW 97 42000 (Fund & Account) (State) % 100 % (Federal)

...CANT: Susan Waldron POSITION (Title): Project Coordinator-Lead Poisoni Prevention Program

...TE OF DEPARTURE: 12/10/00

NATURE OF TRIP (School, Meeting, Convention, etc.): Conference

2000 National Lead Grantee Conference (Name) 12/10-13/00 (Date) Atlanta, GA (Location)

MODE OF TRAVEL (Private - Public): Public

REFUNDABLE

ESTIMATED COST: $ 375.00 (Travel) $ Hotel-424.00 perdiem-180.00 (per diem) $ No Reg. Fee Taxi-25.00 (Other) $ 1004.00 (Total)

JUSTIFICATION FOR TRIP: As Program Coordinator for the Lead Poisoning Prevention Program Ms. Waldron has been ask to attend this "by invitation only conference" for grant recepients. The 2000 National Grantee Conference is held once every two years and attendance at this conference is a budgeted item as directed by CDC. Funding for attendance at this conference is covered by ATSDR Cooperative Agreement Program to Build Capacity to Conduct Site-Specific Environmental Health Education and Monitoring Activities"

DURATION OF TRIP WILL INCLUDE 4 DAYS AT MEETING AND 1 DAYS ENROUTE.

TOTAL OF 5 DAYS.

APPROVED: SKW [signature] Service or Office Chief/Division Director

KC

APPROVAL AND TRAVEL AUTHORIZATION

The individual named hereon is authorized to perform official travel as indicated.

[signature] Commissioner

11/13/00 Date

OSDH Form No. 81
(Rev. 8/78)

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: 66 ITINERARY/INVOICE NO. 0048820 DATE: 06 DEC 00
CUSTOMER NBR: 012057 -WSEIEP PAGE: 01

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVSION
ORDERED BY MELISSA 271 1262
PURCHASE ORDER NUMBER X001821V023
FOR: WALDRON/SUSAN REF

PERSONAL IDENTIFIER(S) REDACTED

Ck# 107563 was only $375.00 - $11 = Due on this invoice

TWA TICKETLESS CONFIRMATION NBR 3APLNF

10 DEC 00 - SUNDAY

AIR	TRANS WORLD AIRLINES FLT:484	ECONOMY	
	LV TULSA	805A	EQP: MD-80
			01HR 16MIN
	AR ST LOUIS INTL	921A	NON-STOP
	ARRIVE: MAIN TERMINAL		REF: 3APLNF
	WALDRON/SUSAN SEAT-24A		
AIR	TRANS WORLD AIRLINES FLT:518	ECONOMY	
	LV ST LOUIS INTL	1016A	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 39MIN
	AR ATLANTA	1255P	NON-STOP
			REF: 3APLNF
	WALDRON/SUSAN SEAT-16A		

14 DEC 00 - THURSDAY

AIR	TRANS WORLD AIRLINES FLT:208	ECONOMY	
	LV ATLANTA	1235P	EQP: BOEING 717
			01HR 49MIN
	AR ST LOUIS INTL	124P	NON-STOP
	ARRIVE: MAIN TERMINAL		REF: 3APLNF
	WALDRON/SUSAN SEAT-21A		
AIR	TRANS WORLD AIRLINES FLT:511	ECONOMY	
	LV ST LOUIS INTL	215P	EQP: MD-80
	DEPART: MAIN TERMINAL		01HR 22MIN
	AR TULSA	337P	NON-STOP
			REF: 3APLNF
	WALDRON/SUSAN SEAT-26A		

AIR TICKET	TW7132298746	WALDRON SUSAN	386.00
ELEC TKT			
		SUB TOTAL	386.00
		TOTAL AMOUNT DUE	386.00

Credit 107563 (386.00)

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES. ANY ERRORS SHOULD BE REPORTED TO US IMMEDIATELY
PAYMENT IS DUE UPON RECEIPT OF INVOICE

CONTINUED ON PAGE 2

zero Claim

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS.

TRAVEL AGENTS INCORPORATED

9415 NORTH MAY AVE.

OKLA CITY, OK 73120

2057 12 DEC 00 1 107563

CREDIT MEMO

	STATE DEPT OF HEALTH		STATE DEPT OF HEALTH
	ATTN: DWIGHT BURLESON	0	ATTN: DWIGHT BURLESON
	P.O. BOX 53551	66	P.O. BOX 53551
01	OKLA CITY, OK 73152		OKLA CITY, OK 73152

AIRLINE	FL/CL	DATE	FROM	TO	LEAVE	ARRIVE
ELTA AIRLINES	1556Q	10DEC SUN	TULSA, OK	ATLANTA, GA	1000A	1252P
ELTA AIRLINES	1481Q	14DEC THU	ATLANTA, GA	TULSA, OK	1155A	1257P

WALDRON/SUSAN TKT # 0067132298427 $ 375.00-

PERSONAL IDENTIFIER(S) REDACTED

TKT REF, ORIG INV # 48805

ORIG. DATE OF ISSUE 17NOV

CREDIT MEMO TOTAL $ 375.00-

Posted to #48820

386.00

0

FULL REFUND

BF $ 338.60- TX $ 36.40- AC 01A6930- 107563

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		122841 MK

FOR AGENCY USE: BT11 NW-17 01249Y

CLAIM OF: NANCY C. HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

MK 21101

FOR $ 32.09 AGAINST

Agency, Board, Comm., Dept.: Okla. State [illegible]

IS CAR GOV. OWNED? YES ____ NO xx

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES xx NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
200135	40000	2111	8000000	32.09

OSF - Audited By:

TOTAL AMOUNT $ 32.09

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: 391 - Lead

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to warrant in payment to said assignee
Date: _____
Claimant Signature

WARR NUM: 7707997
WARR DATE: 02/06/2001
CLAIM NO: 122841

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodgi Amour
Miami-Picher-Vicinity-Miami	1	10	20	3							
Miami-Picher-Miami	1	11	20								
Miami-Wyandotte-Vic.-Miami	1	19		30							
Miami-Picher-Miami	1	30	20								
TOTALS			60	33							
			93		93	TOTAL MILES @		34.5¢		PER MILE =	$32.09

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP. $32.09

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE:	TOLLS:
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED $32.09

I Nancy C. Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 01-31 2001

My Commission expires _____ 19__

X Sue Waldron
Approving Supervisor's Signature

Notary Public (or Clerk or Judge)

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act

Chief, Financial Management
Agency's Approving Officer

Title

Agency, Bd., or Div Use

FEB 0 2 2001
OTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OKLAHOMA 74354

OTTAWA, IA

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		1269

FOR AGENCY USE: BTH N0097 [illegible]

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	[illegible]	[illegible]	2111	43200000	207.00
NO X			2114		14.40
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____					

OSF - Audited By:

TOTAL AMOUNT $ 221.40

FOR $ 221.40 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____

Claimant Signature

WARR NUM: 7833785
WARR DATE: 03/14/2001
CLAIM NO: 1269

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
MIAMI	391-LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
~~MAIMI VICINITY~~	~~02~~	~~01~~		~~05~~							
MIAMI-PICHER-MIAMI	02	02	20	04							
MIAMI-OKC-MIAMI	02	13	384	10							
MIAMI-PICHER-MIAMI	02	14	20	04							
MIAMI VICINITY	02	20		06							
MIAMI-COMMERCE-MIAMI	02	21	08	02							
MIAMI-VINITA-MIAMI	02	23	54								
MIAMI-PICHER-MIAMI	02	27	20	04							
MIAMI-GROVE VICINITY-MIAMI	02	28	48	10							
TOTALS			554	46							
			600		TOTAL MILES @ 345				PER MILE =		207.00

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS:	14.40
RENTAL CAR:	PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	221.40

I, SUSAN WALDRON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 3-7, 19 01

My Commission expires _____, 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act of _____

BT IAWA COUNTY HEALTH DEPT
Chief, Financial Management
Agency's Approving Officer

MIAMI, OK 74354 MAR 12 2001

Title Date

Agency, Bd., or Div. Use

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X001821	115390

FOR AGENCY USE
WARRANT # 7490557 DATE: 11/27/2000

CLAIM OF:
TRAVEL AGENTS INC.
731270787

1 1 5 3 9 0

ACCOUNT	SUB-ACTIVITY	OBJECT	CEDA	AMOUNT
000135	42000	2211	939940000	375.00

FOR
$ 375.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
022		375.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001117

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/17/2000	48505	375.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 221110088X 375.00

J/E XREF:

VENDOR: TRAVEL AGENTS INC.
ADDRESS: 9415 NORTH MAY
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 73120

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authonzation order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/21/2000

Title Date

Agency, Bd or Div. Use

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: 66 ITINERARY/INVOICE NO. 0048505 DATE: 17 NOV 00
CUSTOMER NBR: 012057 WSEIEP PAGE: 01

115390 MT

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVSION
ORDERED BY MELISSA 271 1262
PURCHASE ORDER NUMBER X001821V 022

FOR: WALDRON/SUSAN REF: PERSONAL IDENTIFIER(S) REDACTED

DELTA TICKETLESS CONFIRMATION NBR D9648F

10 DEC 00 - SUNDAY

AIR	DELTA AIR LINES INC FLT:1556	COACH	
	LV TULSA	1000A	EQP: BOEING 727-200
			01HR 52MIN
	AR ATLANTA	1252P	NON-STOP
			REF: D9648F
	WALDRON/SUSAN SEAT-17F		

14 DEC 00 - THURSDAY

AIR	DELTA AIR LINES INC FLT:1481	COACH	
	LV ATLANTA	1155A	EQP: BOEING 727-200
			02HR 02MIN
	AR TULSA	1257P	NON-STOP
			REF: D9648F
	WALDRON/SUSAN SEAT-17F		

AIR TICKET	DL7132298427	WALDRON SUSAN	375.00
ELEC TKT			
		SUB TOTAL	375.00
		TOTAL AMOUNT DUE	375.00

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES. ANY ERRORS SHOULD BE REPORTED TO US IMMEDIATELY
PAYMENT IS DUE UPON RECEIPT OF INVOICE

MT

AG-66

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS.

PO X001821 V 10/23

731270787

221110088X

Control No.

Date 11-16-00 mf

Budget Code

Melissa 56223

RECEIVED NOV - 2 2000 Personal Health Finance

OKLAHOMA STATE DEPARTMENT OF HEALTH

INTERSTATE TRAVEL REQUEST/AUTHORIZATION

Susan Waldron - Atlanta Ga 133/01

DIVISION: MCH-Screening & Special Services SS# PERSONAL IDENTIFIER(S) REDACTED

TO BE CHARGED TO: 400 BT11 000135NW97 42000 (Fund & Account) (State) % 100 % (Federal)

APPLICANT: Susan Waldron POSITION (Title): Project Coordinator-Lead Poisoning Prevention Program

DATE OF DEPARTURE: 12/10/00

NATURE OF TRIP (School, Meeting, Convention, etc.): Conference

2000 National Lead Grantee Conference (Name) 12/10-13/00 (Date) Atlanta, GA (Location)

MODE OF TRAVEL (Private - Public): Public

REFUNDABLE

ESTIMATED COST: $ 375.00 (Travel) $ Hotel-424.00 perdiem-180.00 (per diem) $ No Reg. Fee Taxi-25.00 (Other) $ 1004.00 (Total)

JUSTIFICATION FOR TRIP: As Program Coordinator for the Lead Poisoning Prevention Program Ms. Waldron has been ask to attend this "by invitation only conference" for grant recepients. The 2000 National Grantee Conference is held once every two years and attendance at this conference is a budgeted item as directed by CDC. Funding for attendance at this conference is covered by ATSDR Cooperative Agreement Program to Build Capacity to Conduct Site-Specific Environmental Health Education and Monitoring Activities"

DURATION OF TRIP WILL INCLUDE 4 DAYS AT MEETING AND 1 DAYS ENROUTE.

TOTAL OF 5 DAYS.

APPROVED: SKY [signature] Service or Office Chief/Division Director

KC

APPROVAL AND TRAVEL AUTHORIZATION

The individual named hereon is authorized to perform official travel as indicated.

[signature] Commissioner 11/13/00 Date

OSDH Form No. 51 (Rev. 8/78)

ADAIR CO

OSF-Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.	CLAIM OF:
400	340		113007MT	KAREN CORNELL

FOR AGENCY USE: BT11 NW97 004985

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	00135	42000	2111	93250000	~~30.31~~ 27.95
NO X			2112		56.25
			2114		.25
			2115		80.00

FOR $ 164.45 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 7414440
WARR DATE: 11/02/2000
CLAIM NO: 113007

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X ____ NO ____

OSF - Audited By:

TOTAL AMOUNT $ 164.45

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
STILWELL	NEUROCOGNITIVE CONSULTATION -LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2000 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
*TAHLEQUAH-MIAMI-VIC	10	17	83	27	8AM						
MIAMI VIC		18		61							
MIAMI-STILWELL	10	19	95	10		3PM	2	7	25.	56.25	80.00
TOTALS			178	98			2	7			
			276		TOTAL MILES @ .325				PER MILE =		89.70

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED --190 MI OVERPAYMENT ON 9/5-8/2000 SEE ATTCH. -61.75

*CLOSER TO DESTINATION THAN DUTY STATION. CC 108565

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	.25
RENTAL CAR:	PARKING: TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP.	
	TOTAL AMOUNT CLAIMED	164.45

I, KAREN CORNELL the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Karen Cornell 10-23-00
Claimant Signature

State of OKLAHOMA County of ADAIR

Subscribed and sworn before me _____, 19 ____

My Commission expires _____, 19 ____

_____
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

ADAIR CO HEALTH DEPT

Agency's Approving Officer ADAIR COUNTY HEALTH DEPT.
600 W. Hickory St.
Stilwell, OK 74960

OCT 31 2000
Date

Title

Agency, Bd., or Div Use

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
[illegible]	340		[illegible]

FOR AGENCY USE [illegible]

CLAIM OF: KAREN CORNELL

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO ~~OSF-OSS~~
LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES XX
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
[illegible]	[illegible]	2111	–	146.90
		2112		75.00
		2114		.50
		2115		120.00

OSF - Audited By:

TOTAL AMOUNT $ 342.40

FOR $342.40 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION: STILWELL

NATURE OF OFFICIAL BUSINESS: NEUROCOGNITIVE CONSULT.-LEAD PROJECT

Show point travel status began, each point visited and the point travel status ended. (Vicinity-only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1920 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount	TOTAL PER DIEM LODGING
TILWELL-MIAMI-VIC	09	05	190	14	2:45 PM							
AMI-PICHER-MIAMI	09	06	20	02								
AMI-PICHER-MIAMI	09	07	20	02								
AMI VICINITY-STILWELL	09	08	190	14		2:30 PM	2		25	75.00	120	195.00
							2	23 3/4				
TOTALS			420	32								
				452	TOTAL MILES @ 32.5						PER MILE =	0

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS:	.50
RENTAL CAR:	PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	342.40

I, KAREN CORNELL the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 9-8-00, 19 ____

My Commission expires _____, 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Agency's Approving Officer

Title Date

Agency, Bd., or Div. Use

[illegible] Rack

311

ROOM NAME Karen Cornell

ADDRESS PERSONAL IDENTIFIER(S) REDACTED

CITY ZIP

REPRESENTING Adair Co. Health Dept

LICENSE NO. STATE CAR YEAR, MAKE, MODEL

PERSONAL IDENTIFIER(S) REDACTED Sylvia

NOTICE TO GUESTS - This property is privately owned and management reserves the right to refuse service to anyone, and will not be responsible for accidents or injury to guests or for loss of money, jewelry or valuables of any kind.

Date of Arrival 10-17-00 No. of Days 32 Wake Up Call 6:30

No. in Party 1 Rate 40.00 Tx ex

DATE	10/17	10-18						
Forward		40.00						
ROOM	40.00	40.00						
TAX	—	—						
MISC.								
PHONE								
MEALS								
TOTAL	40.00	80.00						

BEST WESTERN INN OF MIAMI
2225 E. Steve Owens Blvd.
Miami, OK 74354 • (918) 542-6681
FAX (918) 542-3777

US TOTAL 80.00

CR CLERK

0 Bal.

CUSTOMER COPY

BEST WESTERN HOTELS
2225 E STEVE OWEN BLVD
MIAMI, OK 743540000
TERMINAL I.D. 00192185
MERCHANT

VISA
PERSONAL IDENTIFIER(S) REDACTED
ROOM EXP. DATE
311 02/04
INVOICE NO. 37148
OCT 17, 00 17:08
000 0160 AUTH CODE 209219

REAUTH CODE

REAUTH AMT

TOTAL AMT 80.00

KAREN K CORNELL

PURCHASER SIGN HERE

X Karen Cornell

Cardholder acknowledges receipt of goods and/or service in the amount of the Total shown hereon and agrees to perform the obligations set forth in the Cardholder's agreement with the issuer.

GENERAL CREDIT FORMS • ST. LOUIS 63045 3 PART RECEIPT

SEE REF CL # ON BACK

OTTAWA CO

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		206296

FOR AGENCY USE: BT12 NW58 A-X

CLAIM OF: Nancy C. Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO X

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00024 0	40002	211	93.200	74.52

FOR $ 74.52
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES X
NO ____

OSF - Audited By:

TOTAL AMOUNT $ 74.52

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date: ____

Claimant Signature

WARRANT (LOCATOR) NO.

WARR DATE: 08/29/2001

WARR NUM: 7199742

CLAIM NO: 206296

OFFICIAL DUTY STATION: Miami

NATURE OF OFFICIAL BUSINESS: Program to build capacity to conduct site specific activities (ottawa) Lead Poisoning 391

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19__ Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vic	7	2		6							
Miami-Picher-Miami	7	11	20								
Miami-Picher-Miami V.	7	12	20	4							
Miami-Fairland-Vic-Miami	7	13	22	10							
Miami-Commerce-Miami	7	16	8								
Miami-Vic	7	17		6							
Miami-Prypr-Vic.-Miami	7	18	104	10							
Miami-Vic.	7	19		6							
TOTALS			174	42							
			216		216 TOTAL MILES @				34.5	PER MILE =	74.52

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):
SHUTTLE:	TELEPHONE: TOLLS:
RENTAL CAR:	PARKING: TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP.
	TOTAL AMOUNT CLAIMED 74.52

I, NANCY C. HORTON the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 8/13, 19, 2001

My Commission expires ____, 19 ____

Susan Waldron
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Chief, Financial Management
Agency's Approving Officer

Ottawa County Health Dept.
Ottawa Co. 1930 North Elm
Miami, Oklahoma 74354
918-540-2481

Title

Date AUG 29 2001

Agency, Bd., or Div. Use

OTTAWA

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		206217

FOR AGENCY USE: BT12 NW58 A X

CLAIM OF: (1) Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO x

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES x NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000240	40002	2111	93.200-	43.47

OSF - Audited By:

TOTAL AMOUNT $ 43.47

FOR $ 43.47 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to warrant in payment to said assignee
Date: _____
Claimant Signature

WARRANT (LOCATOR) NO.

WARR DATE: 08/29/2001
WARR NUM: 7199743
CLAIM NO: 206297

OFFICIAL DUTY STATION: Miami, OK

NATURE OF OFFICIAL BUSINESS: Program to build ca[illegible] [illegible]t site specific [illegible] (Ottawa) Lead Hosp[illegible]ng $391

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodgi Amou
Miami-Commerce-Miami	7	10	8								
Miami-Vic	7	11		16							
Miami-Vic	7	12		8							
Miami-Commerce-Miami-Vic	7	16	8	10							
Miami-Vic	7	17		6							
Miami-Vic	7	19		6							
Miami-commerce-Miami-Vic	7	24		8							
Miami-Afton-Miami	7	27	30								
Miami-Vic	7	30		8							
Miami	7	31	8	10							
TOTALS			54	72							
			126		TOTAL MILES @ 34.5				PER MILE =		43.47

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 43.47

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 8/14, 19 2001

My Commission expires _____, 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Agency's Approval [illegible] County Management
1930 North Elm
Miami, Oklahoma 74354
Title Date
Agency, Bd., or Div. Use 918-540-2481

AUG 23 2001

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		207557

FOR AGENCY USE: BT12 NW58 A-X

CLAIM OF: Nancy Horton (Ottawa)

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	000240	40002	5111	93.200	87.63
NO X					

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

OSF - Audited By:

TOTAL AMOUNT $ 87.63

FOR $ 87.63 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept.

ASSIGNMENT
I hereby assign this claim to ____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: ____
Claimant Signature

MARK DATE: 09/26/2001 7200057 207557

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19__ Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami- Vic- Miami	8	1		6							
Miami-Vic Miami	8	6		6							
Miami-Vic-Miami	8	7		8							
Miami- Quapaw- Miami	8	8	20	6							
Miami- Picher- Miami	8	9	20								
Miami-Vic- Miami	8	10		6							
Miami- Vic- Miami	8	11		8							
Miami-Bartlesville-Vicinity Miami	8	23	152	8							
Miami- Vic- Miami	8	24		8							
Miami- Vic- Miami	8	30		6							
TOTALS			192	62							
			254		TOTAL MILES @ .345				PER MILE =		87.63

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):
SHUTTLE:	TELEPHONE: TOLLS:
RENTAL CAR:	PARKING: TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP.
	TOTAL AMOUNT CLAIMED 87.63

I, Nancy Horton, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C Horton
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me Sept. 4 2001

My Commission expires ____ 19__

Susan Whitman
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or ____

Chief, Financial Management
Agency's Approving Officer

SEP 10 2001
Title

Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354
918-540-2481
Agency, Bd., or Div. Use

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		207558

FOR AGENCY USE: BT12 NW58 A-X

CLAIM OF: Susan Waldron

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000240	40002	211	93.200 -	67.62

OSF - Audited By:

TOTAL AMOUNT $ 67.62

FOR $ 67.62 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to warrant in payment to said assignee

Date: _____

Claimant Signature

WARRANT (LOCATOR) NO.

WARR NUM: 2260596 DATE: 09/19/2001 CLAIM NO: 207558

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	TOTAL PER DIEM ONGOING
Miami- Vic- miami	8	1		6							
Miami- Vic- Miami	8	2		6							
Miami-Vic- Miami	8	7		8							
Miami- Quapaw- Miami	8	8	20	2							
Miami-Picher- Miami	8	9	20								
Miami-Vic-Miami	8	10		6							
Miami-Vic- Miami	8	11		12							
Miami- Picher-Miami	8	15	20								
Miami- picher- Miami	8	16	20								
Miami- Vic- Miami	8	21		6							
Miami- Commerce-Miami	8	22	8	2							
* Miami- Afton- Miami	8	23	30								
TOTALS			126 70								
			196		TOTAL MILES @ .345				PER MILE =		67.62

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED
* rode w/ coworker to Muskogee

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:		TELEPHONE:	TOLLS:	
RENTAL CAR:		PARKING:	TOTAL MISC.	
OTHER LOCAL TRANSP.		OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
			TOTAL AMOUNT CLAIMED	67.62

I, Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of ottawa

Subscribed and sworn before me Sept 4 19 2001

My Commission expires _____ 19 _____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Agency's Approving Officer Ottawa County Health Dept.
Chief, Financial Management
1930 North Elm
Title Miami, Oklahoma 74354
Agency, Bd., or Div. Use 918-540-2481 SEP 10 2001

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
	340		

FOR AGENCY USE

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
PERSONAL IDENTIFIER(S) REDACTED				
OSF - Audited By:			TOTAL AMOUNT $	

IS CAR GOV. OWNED?
YES ____
NO X
LICENSE NO

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES X
NO ____

FOR
$
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
_____
Claimant Signature

WARRANT (LOCATOR) NO.

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19__		Mileage Claimed		Travel Status Hour		No. of		Per Diem		Lodging Amount	TOTAL PER DIEM LODGING
	Mo.	Day	Map	Vicinity	Entered	Ended	Days	Hrs.	Rate	Amount		
Miami- Vic- Miami	8	28		8								
Miami- Vic- Miami	8	30		6								
Miami-Commerce-Vic-Miami	8	31	8	8								
TOTALS												

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		207611

FOR AGENCY USE: BT72 NW58 A-X

CLAIM OF: OKLAHOMA
Remedios Tirres

PERSONAL IDENTIFIER(S) REDACTED
S.S. No. _____

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ___	000240	40002	2111	93.200	30.71
NO X			2114		2.00
LICENSE NO					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ___					
	OSF - Audited By:			TOTAL AMOUNT $	32.71

FOR
$ 32.71
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

MARK HUSS DATE: 09/10/2001
CLAIM NO: 207611

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)

	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amt
Miami Vic - Miami	8	7		15							
Miami Vic Miami	8	11		20							
Miami Vinita Miami	8	28	54								
TOTALS			54	35							
			89		TOTAL MILES @ .345				PER MILE =		30.71

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: 2.00	
RENTAL CAR:	PARKING:	TOTAL MISC.	2.00
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	30.71
		TOTAL AMOUNT CLAIMED	32.71

I, Remedios Tirres, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Remedios Tirres
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me Sept 4 19 2001

My Commission expires _____ 19 ___

Susan Waldron
Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or _____

SEP 10 2001
Date

Agency's Approving Officer

Chief, Financial Management
Title

Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354
918-540-2481

Agency, Bd., or Div. Use

Ottawa

OSF Form 19 (Revised 7/96)
STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		210784

FOR AGENCY USE: BT12 NW58 A-X

CLAIM OF: Nancy C. Horton

PERSONAL IDENTIFIER(S) REDACTED
S.S. No. _____

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	000240	40002	2111	93.200 -	39.33
NO X					
LICENSE NO.					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $ 39.33	

FOR $ 39.33 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
_____ Claimant Signature

WARR NUM: 7556428
WARR DATE: 10\12\2001
CLAIM NO: 210784

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami- Commerce-Miami	9	10	8								
Miami Fairland Miami	9	14	22								
Miami Grove Miami	9	15	48								
Miami Vic Miami	9	18		6							
Miami Vic Miami	9	25		30							
TOTALS			78	36							
			114		TOTAL MILES @ .345				PER MILE =		39.33

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 39.33

I, Nancy C. Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me Sep. 28, 2001

My Commission expires _____, 19____

_____ Notary Public (or Clerk or Judge)

Susan Waldron
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

R. [illegible]
Chief, Financial Management
Agency's Approving Officer

OCT 0 9 2001
Date

Ottawa County Health Dept.
Title
1930 North Elm
Agency, Bd., or Div. Use Miami, Oklahoma 74354
918-540-2481

Ottawa

OSP Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		210786

FOR AGENCY USE: BT12 NW58 A-X

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	000240	40002	2111	93.200 —	72.11
NO X					

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

OSF - Audited By:

TOTAL AMOUNT $ 72.11

FOR $ 72.11 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
_____ Claimant Signature

WARRANT (LOCATOR)
MARK DATE: 10\12\2001
MARK NUM: 7558430
CLAIM NO: 210786

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead Project

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1991 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodg Amo
Miami Commerce Miami	9	6	8								
Miami Miami	9	13	20								
Miami Vic Miami	9	14		8							
Miami Grove Miami	9	15	48								
Miami Commerce Miami	9	18	8								
Miami Vic Miami	9	20		15							
Miami Picher Miami	9	21	20								
Miami /Vic Miami	9	24		15							
Miami Vic Miami	9	25		45							
Miami Quapaw Miami	9	26	20	2							
TOTALS			124 209	85					TOTAL MILES @	.345	PER MILE =	72.11

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):
SHUTTLE:	TELEPHONE: TOLLS:
RENTAL CAR:	PARKING: TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS: TOTAL LOCAL TRANSP.
	TOTAL AMOUNT CLAIMED 72.11

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me Sept. 28 2001

My Commission expires _____ 19 ____

_____ Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or

Chief, Financial Management
Agency's Approving Official

Ottawa Co.
Title

1930 F.
Date

Agency, Bd., or Div. Use Miami, Okla.
918-540

OCT 0 9 2001

Time And Effort Cost
Cost Accumulation Schedule

December 26, 2001
Prepared By

Grant Name: Conduct Site Spec. Activities
Grant Number U50 / ATU686520-03
Grant Period 09/29/2000 TO 09/28/2001
Program Code 391

[redacted]

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200010	91.03	168.57	0.00	704.31
200011	96.92	149.59	0.00	791.19
200012	62.26	111.22	0.00	1,208.53
200101	46.72	99.21	0.00	966.48
200102	60.50	115.88	0.00	747.34
200103	91.94	139.66	0.00	696.20
200104	77.55	196.02	0.00	1,059.63
200105	40.49	96.36	0.00	431.55
200106	46.17	153.10	0.00	910.81
200107	40.93	76.26	0.00	315.10
200108	58.71	120.59	0.00	577.18
200109	172.31	134.24	0.00	537.33
Total	**885.53**	**1,560.70**	**0.00**	**8,945.65**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200010	11.98	22.18	0.00	92.69
200011	9.38	14.48	0.00	76.59
200012	8.22	14.69	0.00	159.63
200101	4.81	10.22	0.00	99.52
200102	6.24	11.96	0.00	77.10
200103	10.41	15.81	0.00	78.82
200104	8.29	20.96	0.00	113.32
200105	4.49	10.69	0.00	47.90
200106	5.42	17.96	0.00	106.82
200107	4.26	7.94	0.00	32.81
200108	5.89	12.10	0.00	57.94
200109	34.55	26.92	0.00	107.75
Total	**113.94**	**185.91**	**0.00**	**1,050.89**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
103.01	190.75	0.00	797.00
106.30	164.07	0.00	867.78
70.48	125.91	0.00	1,368.16
51.53	109.43	0.00	1,066.00
66.74	127.84	0.00	824.44
102.35	155.47	0.00	775.02
85.84	216.98	0.00	1,172.95
44.98	107.05	0.00	479.45
51.59	171.06	0.00	1,017.63
45.19	84.20	0.00	347.91
64.60	132.69	0.00	635.12
206.86	161.16	0.00	645.08
999.47	**1,746.61**	[redacted]	**9,996.54**

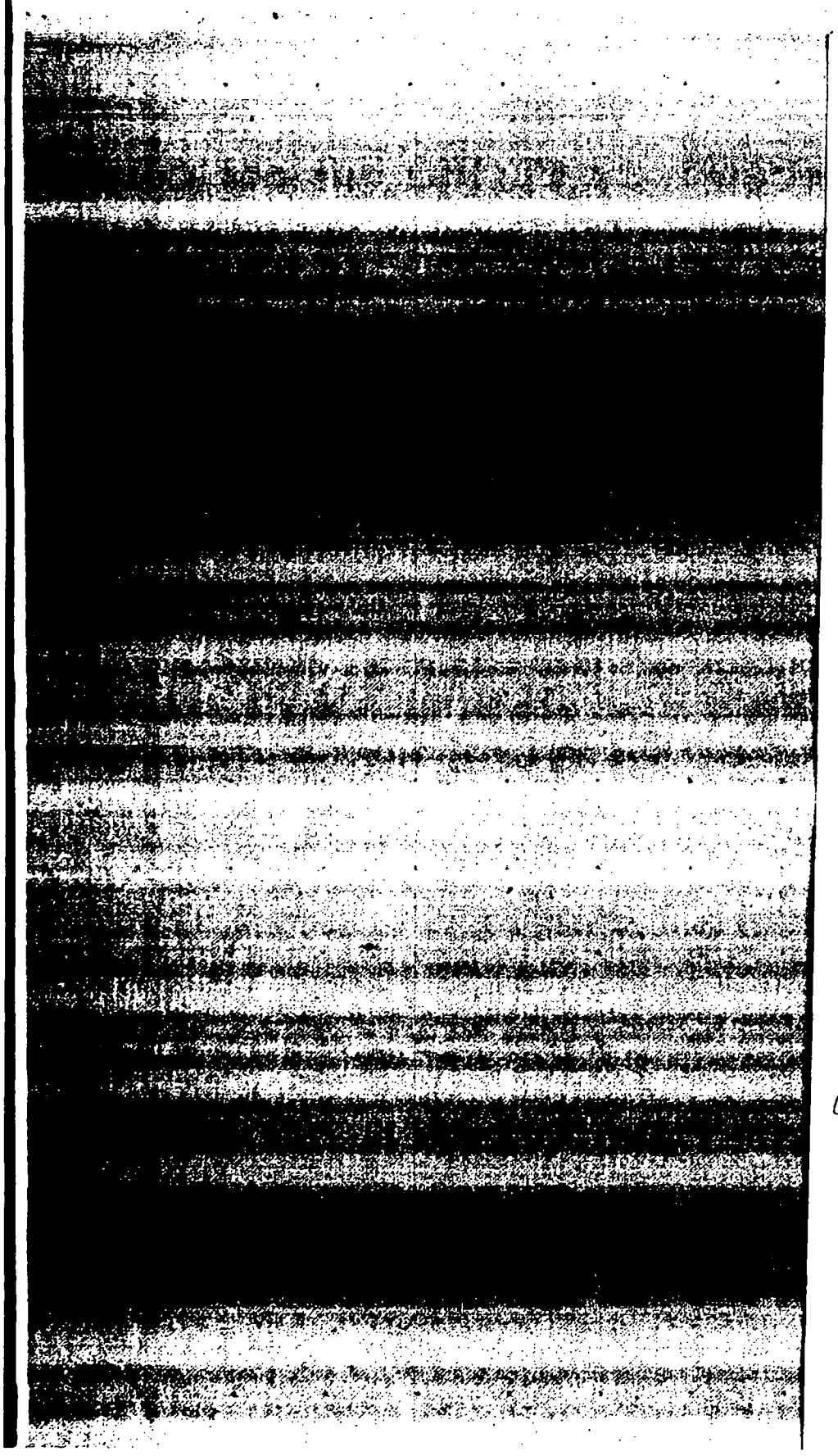
OTHER

9/29/2000 to 9/28/2001

Claims	45,285.64
PROGCOST - Other	9,996.54
Worker's Comp	898.15
Total Other	$ 56,180.33

Claims are the direct costs and PROGCOST are the allocated costs. These costs are for things like office supplies and test kits for blood lead. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED



512.24 +
10.02 +
337.83 +
354.61 +
122.73 +
1,728.00 +
195.00 +
195.00 +
195.00 +
260.26 +
155.12 +
138.75 +
191.28 +
311.00 +
243.17 +
150.00 +
7.90 +
7.90 +
7.90 +
7.90 +
7.90 +
7.90 +
7.90 +
174.00 +
174.00 +
174.00 +
174.00 +
174.00 +
174.00 +
21.00 +
195.00 +
94.23 +
174.00 +
50.00 +
5,710.00 +
390.00 +
OTHER 710.42 +
1,294.42 +
3,212.84 +
2,955.84 +
855.00 +
2,572.84 +
3,024.50 +
3,034.34 +
3,340.34 +
3,034.84 +
8,295.68 +

048

45,285.64 *

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X045935	118852

FOR AGENCY USE: WARRANT # 7603555 DATE: 01/05/2001

CLAIM OF:
MEDIASOFT/MICROAGE
731179836

1
1
8
8
5
2

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	88042	3614	000000000	512.24

FOR
$ 512.24

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	512.24
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001221

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/18/2000	68654	512.24

THIS SPACE FOR AGENCY USE

400BT11 000135NW0A 3614AAAAAX 512.24

J/E XREF:

VENDOR: MEDIASOFT
ADDRESS: P O BOX 960053
ADDRESS:
CITY/ST/ZIP: OKLA CITY OK 731960053

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

12/29/2000
Date

Agency, Bd or Div. Use

118852 PR

MEDIASOFT, INC.
Oklahoma City, OK
(405) 607-2000

F.E.I./S.S. 73-1179836

INVOICE

PLEASE REMIT TO:
MEDIASOFT, INC.
Post Office Box 960053
Oklahoma City, OK 73196-0053

BILL TO: OKLAHOMA DEPT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO: OKLA STATE DEPT OF HEALTH
SHIPPING & RECEIVING
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117

	DATE	ORDER NUMBER	ORDER DATE	CUSTOMER NUMBER	CUSTOMER P.O. NUMBER	TERMS	[illegible]
68654	12/18/00	118250	12/14/00	831500	X045935	Net 10 Days UPS	11

	ITEM DESCRIPTION	[illegible]	[illegible]	[illegible]
	****** DROP SHIPMENT *****			
	Config. Order? N No			
	Type of Install N None			
6615DN	NO.15 BLACK INKJET CARTRIDGE FOR HP DESKJET 810C & 812C	4.00	23.790	95.16
1823D	C1823D TRI-COLOR INK CARTRIDGE	4.00	27.990	111.96
1645A	BLACK PRINT CART 850C	4.00	25.190	100.76
6578AN	NO.78 LG TRI-COL INK CART DJ 930C 970C P1000 P1100	4.00	51.090	204.36
	Subtotal			512.24
	Total Due			512.24

731179836 NWOA

X045935 PURCHASE DOCUMENT	000135 ACCOUNT NO.
001 COMPLETE / PARTIAL	400BT11 FUND NO.
88042 MATH CHECKED	3614A-X OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
PReam 12-29-00 INVOICE APPROVED	DATE

RECEIVED
2000 DEC 20 P 4:24
FINANCIAL MANAGEMENT

FINANCE CHARGE OF 1.5% WILL BE ADDED FOR ALL
VOICES NOT PAID ACCORDING TO THE TERMS ABOVE.

PACKING SLIP

RECEIVED
DEC 1 9 2000
SHIPPING & RECEIVING

Ship From

MEDIASOFT INC
1809 W. FRANKFORD STE. 100
CARROLLTON, TX 75007

Ship To

PO#X045935
OKLAHOMA DEPT OF HEALTH
1000 NE 10TH ST
OKLAHOMA CITY OK 73117-1207

Ship Date	Ship Via	Customer PO
12/15/2000	UPS GROUND	63182

Line Nbr	PO Line	Qty Order.	Qty Ship	SKU #	Description	Price	Extended/ Retail
001		4	4	115616	NO.15 BLACK INKJET CARTRIDGE FOR HP DESKJET 810C & 812C SUPL CPU: MSD UPC: 0025184204556 MFG PART: C6615DN CARTON #s: 00001		
002		4	4	116071	LG TRICOLOR INK CART F/ DJ 710 720 722 810 812 880 890 895 1120C SUPL CPU: MSD UPC: 0088698687277 MFG PART: C1823D CARTON #s: 00001		
003		4	4	397944	NO.45 LG BLACK INK F/DJ 710 750 850 880 895 930 950 970 1120 1600 SUPL CPU: MSD UPC: 0088698004289 MFG PART: 51645A CARTON #s: 00001		
004		4	4	114314	NO.78 LG TRI-COL INK CART DJ 930C 950C 970C P1000 P1100 SUPL CPU: MSD UPC: 0088698993019 MFG PART: C6578AN CARTON #s: 00001		

Carton Numbers Shipped: 00001

Total Quantity Shipped: 16
Total Cartons Shipped: 1

Trk Nbrs: 1Z78247Y0356346415

Shirley Logo
PAM PIERRY 4470

PRODUCTS ARE REGULATED BY THE U.S. DEPT. OF COMMERCE OFFICE OF EXPORT ADMIN. AND ARE SUBJECT TO EXPORT CONTROL REGULATIONS.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	A700001	213051

FOR AGENCY USE
WARRANT # 7429507 DATE: 11/01/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	3113	000000000	10.02
000235	42000	3113	931100000	11.85

CLAIM OF:
METROCALL
541215634

2
1
3
0
5
1

FOR
$ 21.87

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $ 21.87
		OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010928

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
08/25/2001	50502255428	21.87

THIS SPACE FOR AGENCY USE

[redacted]
400BX12 000235NH0A 3113AAAAAX 11.85

IPO NO: 000370
J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CTR
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 10/29/2001

Title Date

Agency, Bd or Div. Use

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 8808153
Invoice Date: 08/25/01
P. O. Number: Y001235

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
[illegible]	78.47	0.00	137.99	63.20	201.19

Payments received after 08/25/01 will be reflected on your next invoice.

SUMMARY OF ACCOUNT CHARGES

Previous Balance		$ 215.46
Payments Received Through 08/25/01		$ 78.47
Adjustments to Previous Balance		
Total Balance Forward		**$ 137.99**
Current Charges		
Service Charges		$ 63.20
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		**$ 63.20**

Pay Total Amount Due by 09/18/01 to Avoid Late Fee

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
63.20	62.68	75.31	0.00	201.19

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	8808153	08/25/01	63.20	201.19	

If You Have Questions, Call Customer Care **1 405 440-1400** ☐ Check here for change of address (see reverse)

AV 01 000842 70062E 21 A**5DGT
STATE-DOH/CHILD ABUSE
ATTACCOUNTS PAYABLE
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000020119000006320880815328010900 3

General Terms and Conditions

This [illegible] agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The Term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.

1. SERVICE.

a. Term/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle end dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid in Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any disputes must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rental Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement, in addition to all other remedies available to us. We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Records/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are undeliverable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 20 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rental Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of like vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or dam[age] does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthori[zed] repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to termi[nate] Loss/Damage Protection if we determine that loss or damage of rental Pagers has been excessive. Upon advance notice, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochu[re, if] any, as amended from time to time.

c. Your Responsibility for Rental Pager. If the rental Pager is not covered by Loss/Damage Protection and if you do not dep[osit] with us a sum covering the cost of any rental Pager, then in the event (i) any Pager rented from us is lost, stolen, destro[yed] or damaged beyond repair, with or without your fault, or (ii) if you do not return the rental Pager in good condition to us u[pon] our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or re[ntal] charges for such Pager, plus the replacement cost of the rental Pager, as specified in this Agreement. Payments m[ade] pursuant to this Agreement shall not in any way affect title to the rental Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you wi[ll not] give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

e. Maintenance for Your Rental Pager. Company will provide Maintenance (as defined in paragraph 5 below), and the fe[e for] this is included in your Service charges.

5. MAINTENANCE

"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, prov[ided] such repair is reasonable and necessary component parts are available. Maintenance does not include replacement of [a] Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intent[ional] abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

If you request Maintenance for Pagers not rented from us, you agree to pay the required charges, and we agree to repa[ir] Pager(s) when the need for repair arises from normal wear and tear and/or equipment defect or malfunction. We, in our [sole] discretion, retain the right to deny Maintenance on any non-rental Pagers.

The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended [from] time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER, F[OR] INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAU[SES] BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS. O[UR] LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING [THE] AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUC[H AS] LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NOT [BE] LIABLE FOR (i) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR [ANY] EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (ii) INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT LI[ABLE] FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.

b. Indemnification. YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND [ANY] UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YO[UR] PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR S[OLE] NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND CO[STS] INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURV[IVE] TERMINATION OF THIS AGREEMENT

c. No Warranties. WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCL[AIM] ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTIC[ULAR] PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND [YOU] SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND [ANY] STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURV[IVE] TERMINATION OF THIS AGREEMENT

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You autho[rize] our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic di[aling] equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are [then] released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited [in the] U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your add[ress]. Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your [notice] must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not gi[ve] notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents directl[y or] indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which [may] only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises [made] to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unle[ss we] accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreemen[t will] be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they m[ay be] amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, term[s and] conditions are regulated by a state agency or the FCC, the regulations are available for your inspection; if there i[s any] inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: ______________________________

Attn: ______________________________

New Address: ______________________________

City: ______________________________

State: ____________________ Country: __________

Zip: ______________________________

Phone Number: ______________________________

James Tally
N Norton

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

770-1192
S. Waldron
0915 77
0725 $105
202 0919

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 8808153
Invoice Date: 08/25/01
P. O. Number: Y001235

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
216.46	78.47	0.00	137.99	63.20	201.19

Payments received after 08/25/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 216.46
Payments Received	$ 78.47
Total Balance Forward	$ 137.99

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-4712	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 620-9425	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 620-9604	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 630-3444	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 636-8629	DD with Extended Coverage	08/29/01 Thru 09/28/01	$ 3.95
(405) 647-2312	DD with Extended Coverage	08/29/01 Thru 09/28/01	$ 3.95
(405) 647-6076	DD	08/29/01 Thru 09/28/01 ?	$ 3.95
(405) 660-7923	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 690-0290	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 690-4708	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 770-1192	DD with Extended Coverage	08/29/01 Thru 09/28/01 ?	$ 3.95
(405) 770-3304	DD	08/29/01 Thru 09/28/01	$ 3.95

*** Continued on next page ***

General Terms and Conditions

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. **YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.**

1. SERVICE.

a. Terms/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. *Failure to cooperate will result in your liability for all fraudulent usage.*

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid In Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any disputes must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rented Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement, in addition to all other remedies available to us. We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Reports/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. *It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with* other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are unidentifiable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 20 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rental Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of like vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or dam does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthor repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to termi Loss/Damage Protection if we determine that loss or damage of rented Pagers has been excessive. Upon advance notice, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochu ary, as amended from time to time.

c. Your Responsibility for Rented Pager. If the rented Pager is not covered by Loss/Damage Protection and if you do not pay with us a sum covering the cost of any rented Pager, then in the event (i) any Pager rented from us is lost, stolen, destro or damaged beyond repair, with or without your fault, or (ii) if you do not return the rented Pager in good condition to us upon our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or n charges for such Pager, plus the replacement cost of the rented Pager, as specified in this Agreement. Payments pursuant to this Agreement shall not in any way affect title to the rented Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you wil give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

e. Maintenance for Your Rented Pager. Company will provide Maintenance (as defined in paragraph 5 below), and the fe this is included in your Service charges.

5. MAINTENANCE.

"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, prov such repair is reasonable and necessary component parts are available. Maintenance does not include replacement of Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intenti abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

If you request Maintenance for Pagers not rented from us, you agree to pay the required charges, and we agree to repai Pager(s) when the need for repair arises from normal wear and tear and/or equipment defect or malfunction. We, in our discretion, retain the right to deny Maintenance on any non-rental Pagers.

The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended f time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER F INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAU BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUCH LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NOT LIABLE FOR (I) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (II) INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT LIA FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.

b. Indemnification. YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YO PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR SO NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND CO INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURV TERMINATION OF THIS AGREEMENT.

c. No Warranties. WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCL ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICU PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURV TERMINATION OF THIS AGREEMENT.

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You authori our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic du equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are th released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited in U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your addre Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your no must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Priorities. These General Terms and Conditions, together with any other documents directly indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which m only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises ma to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement sh be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms conditions are regulated by a state agency or the FCC, the regulations are available for your inspection. If there is a inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: _____

Attn: _____

New Address: _____

City: _____

State: _____ Country: _____

Zip: _____

Phone Number: _____

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 8808153
Invoice Date: 08/25/01
P. O. Number: Y001235

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
215.48	78.47	0.00	137.01	63.20	201.15

Payments received after 08/25/01 will be reflected on your next invoice.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 770-6946	DD	08/29/01 Thru 09/28/01	$ 3.95
(405) 800-6917	DD with Extended Coverage	08/29/01 Thru 09/28/01	$ 3.95
(405) 800-8277	Extra Access Number		$ 0.00
(918) 220-6504	DD	08/29/01 Thru 09/28/01	$ 3.95
(918) 220-6511	DD	08/29/01 Thru 09/28/01	$ 3.95
Total Current Activity			$ 63.20

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. **YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.**

1. SERVICE.

a. Term/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for all service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Charges. Time is of the essence for payment. Therefore, you agree to pay us a monthly $5 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid In Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any dispute must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rented Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement. In addition to all other remedies available to us, We may require reconnection charges to restore Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Reports/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are unredeemable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 20 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rental Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of like vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or damage does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthorized repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to terminate Loss/Damage Protection if we determine that loss or damage of rental Pagers has been excessive. Upon advance notice, we, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochure, if any, as amended from time to time.

c. Your Responsibility for Rental Pager. If the rental Pager is not covered by Loss/Damage Protection and if you do not deposit with us a sum covering the cost of any rental Pager, then in the event (i) any Pager rented from us is lost, stolen, destroyed, or damaged beyond repair, with or without your fault, or (ii) if you do not return the rental Pager in good condition to us upon our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or rental charges for such Pager, plus the replacement cost of the rental Pager, as specified in this Agreement. Payments made pursuant to this Agreement shall not in any way affect title to the rental Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you will not give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

e. Maintenance for Your Rental Pager. Company will provide Maintenance (as defined in paragraph 5 below), and the fee for this is included in your Service charges.

5. MAINTENANCE.

"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, provided such repair is reasonable and necessary component parts are available. Maintenance does not include replacement of any Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intentional abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

If you request Maintenance for Pagers not rented from us, you agree to pay the required charges, and we agree to repair the Pager(s) when the need for repair arises from normal wear and tear and/or equipment defect or malfunction. We, in our sole discretion, retain the right to deny Maintenance on any non-rental Pagers.

The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended from time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. **WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER, FOR INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAUSES BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS. OUR LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING THE AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUCH AS LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NOT BE LIABLE FOR (i) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR ANY EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (ii) THE INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT LIABLE FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.**

b. Indemnification. **YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND ANY UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YOUR PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR SOLE NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND COSTS INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.**

c. No Warranties. **WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCLAIM ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND YOU SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND ANY STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.**

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You authorize our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic dialing equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are then released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited in the U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your address. Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your notice must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give you notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents directly or indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which may only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises made to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless we accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement shall be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may be amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms and conditions are regulated by a state agency or the FCC, the regulations are available for your inspection. If there is any inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: _____

Attn: _____

New Address: _____

City: _____

State: _____ Country: _____

Zip: _____

Phone Number: _____

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 8170567
Invoice Date: 07/28/01
P. O. Number: Y001235

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
153.78	0.00	0.00	153.78	62.68	216.46

Payments received after 07/28/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance	$ 153.78	
Payments Received Through 07/28/01		
Adjustments to Previous Balance		
Total Balance Forward		$ 153.78
Current Charges		
Service Charges	$ 62.68	
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		$ 62.68

Pay Total Amount Due by 08/21/01 to Avoid Late Fee

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
62.68	82.68	71.10	0.00	216.46

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	8170567	07/28/01	62.68	216.46	

If You Have Questions, Call Customer Care 1 405 440-1400 ☐ Check here for change of address (see reverse)

AV 01 000862 29876E 21 A**5DGT
STATE-DOH/CHILD ABUSE
ATTACCOUNTS PAYABLE
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000021646000006268817056728010800b

General Terms and Conditions

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The Term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. **YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.**

1. SERVICE.

a. Terms/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Available/Uninterruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Deposits. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid in Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any disputes must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rental Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement. In addition to all other remedies available to us We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Reports/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 60 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are undeliverable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 20 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay the Charge and a rental Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of the vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or damage does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthorized repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to terminate Loss/Damage Protection if we determine that loss or damage of rental Pagers has been excessive. Upon advance notice, we, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochure, if any, as amended from time to time.

c. Your Responsibility for Rental Pager. If the rental Pager is not covered by Loss/Damage Protection and if you do not deposit with us a sum covering the cost of any rental Pager, then in the event (i) any Pager rented from us is lost, stolen, destroyed, or damaged beyond repair, with or without your fault, or (ii) if you do not return the rental Pager in good condition to us upon our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or rental charges for such Pager, plus the replacement cost of the rental Pager, as specified in this Agreement. Payments made pursuant to this Agreement shall not in any way affect title to the rental Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you will not give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

e. Maintenance for Your Rental Pager. Company will provide Maintenance (as defined in paragraph 5 below), and the fee for this is included in your Service charges.

5. MAINTENANCE.

"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, provided such repair is reasonable and necessary component parts are available. Maintenance does not include replacement of any Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intentional abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

If you request Maintenance for Pagers not rented from us, you agree to pay the required charges, and we agree to repair the Pager(s) when the need for repair arises from normal wear and tear and/or equipment defect or malfunction. We, in our sole discretion, retain the right to deny Maintenance on any non-rental Pagers.

The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended from time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. **WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER, FOR INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAUSES BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS. OUR LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING THE AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUCH AS LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NOT BE LIABLE FOR (I) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR ANY EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (II) THE INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT LIABLE FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.**

b. Indemnification. **YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND ANY UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YOUR PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR SOLE NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND COSTS INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.**

c. No Warranties. **WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCLAIM ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND YOU SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND ANY STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.**

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You authorize our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic dialing equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are then released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited in the U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your address. Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your notice must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give you notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents directly or indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which may only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises made to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless we accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement shall be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may be amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms and conditions are regulated by a state agency or the FCC, the regulations are available for your inspection. If there is any inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: _____

Attn: _____

New Address: _____

City: _____

State: _____ Country: _____

Zip: _____

Phone Number: _____

RECEIVED
2001 NOV -8 P 4:01
FINANCIAL MANAGEMENT

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 8170567
Invoice Date: 07/28/01
P. O. Number: Y001235

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Payments received after 07/28/01 will be reflected on your next invoice.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance Payments Received	$ 153.78
Total Balance Forward	$ 153.78

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-4712	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 559-5917	DD	07/27/01 Thru 07/28/01	$ .13CR
(405) 620-9425	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 620-9604	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 630-3444	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 630-3743	DD	07/27/01 Thru 07/28/01	$ .13CR
(405) 636-5771	DD	07/27/01 Thru 07/28/01	$ .13CR
(405) 636-8629	DD with Extended Coverage	07/29/01 Thru 08/28/01	$ 3.95
(405) 647-2312	DD with Extended Coverage	07/29/01 Thru 08/28/01	$ 3.95
(405) 647-6076	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 660-7923	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 690-0290	DD	07/29/01 Thru 08/28/01	$ 3.95

*** Continued on next page ***

General Terms and Conditions

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The Term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. **YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.**

1. SERVICE.

a. Terms/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid in Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any disputes must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rental Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement, in addition to all other remedies available to us. We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Records/References. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are undeliverable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 20 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rental Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of like vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or damage does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthorized repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to terminate Loss/Damage Protection if we determine that loss or damage of rental Pagers has been excessive. Upon advance notice, we, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochure, if any, as amended from time to time.

c. Your Responsibility for Rented Pager. If the rental Pager is not covered by Loss/Damage Protection and if you do not deposit with us a sum covering the cost of any rental Pager, then in the event (i) any Pager rented from us is lost, stolen, destroyed, or damaged beyond repair, with or without your fault, or (ii) if you do not return the rental Pager in good condition to us upon our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or rental charges for such Pager, plus the replacement cost of the rental Pager, as specified in this Agreement. Payments made pursuant to this Agreement shall not in any way affect title to the rental Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you will not give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

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b. Indemnification. **YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND ANY UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YOUR PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR SOLE NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND COSTS INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.**

c. No Warranties. **WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCLAIM ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND YOU SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND ANY STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.**

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a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You authorize our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic dialing equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are then released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited in the U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your address. Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your notice must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give you notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents directly or indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which may only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises made to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless we accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement shall be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may be amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms and conditions are regulated by a state agency or the FCC, the regulations are available for your inspection; if there is any inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: _____

Attn: _____

New Address: _____

City: _____

State: _____ Country: _____

Zip: _____

Phone Number: _____

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 8170567
Invoice Date: 07/28/01
P. O. Number: Y001235

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
153.78	0.00	0.00	153.78	62.68	216.46

Payments received after 07/28/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 800-8787	DD	07/27/01 Thru 07/28/01	$ .13CR
(405) 800-4708	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 770-1192	DD with Extended Coverage	07/29/01 Thru 08/28/01	$ 3.95
(405) 770-3304	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 770-6946	DD	07/29/01 Thru 08/28/01	$ 3.95
(405) 800-8917	DD with Extended Coverage	07/29/01 Thru 08/28/01	$ 3.95
(405) 800-8277	Extra Access Number		$ 0.00
(918) 220-6504	DD	07/29/01 Thru 08/28/01	$ 3.95
(918) 220-6511	DD	07/29/01 Thru 08/28/01	$ 3.95
Total Current Activity			$ 62.68

General Terms and Conditions

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. **YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.**

1. SERVICE.

a. Terms/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measure we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid in Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any dispute must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rental Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement. In addition to all other remedies available to us We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Reports/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are unidentifiable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 30 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rental Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of the vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or damage does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthorized repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to terminate Loss/Damage Protection if we determine that loss or damage of rental Pagers has been excessive. Upon advance notice, we, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochure, if any, as amended from time to time.

c. Your Responsibility for Rented Pager. If the rental Pager is not covered by Loss/Damage Protection and if you do not deposit with us a sum covering the cost of any rental Pager, then in the event (i) any Pager rented from us is lost, stolen, destroyed, or damaged beyond repair, with or without your fault, or (ii) if you do not return the rental Pager in good condition to us upon our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or rental charges for such Pager, plus the replacement cost of the rental Pager, as specified in this Agreement. Payments made pursuant to this Agreement shall not in any way affect title to the rental Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you will not give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

e. Maintenance for Your Rental Pager. Company will provide Maintenance (as defined in paragraph 5 below), and the fee for this is included in your Service charges.

5. MAINTENANCE.

"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, provided such repair is reasonable and necessary component parts are available. Maintenance does not include replacement of any Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intentional abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

If you request Maintenance for Pagers not rented from us, you agree to pay the required charges, and we agree to repair the Pager(s) when the need for repair arises from normal wear and tear and/or equipment defect or malfunction. We, in our sole discretion, retain the right to deny Maintenance on any non-rental Pagers.

The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended from time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER, FOR INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAUSES BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS. OUR LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING THE AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUCH AS LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NOT BE LIABLE FOR (i) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR ANY EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (ii) THE INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT LIABLE FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.

b. Indemnification. YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND ANY UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YOUR PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR SOLE NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND COSTS INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.

c. No Warranties. WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCLAIM ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND YOU SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND ANY STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You authorize our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic dialing equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are then released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited in the U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your address. Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your notice must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give you notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents directly or indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which may only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises made to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless we accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement shall be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may be amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms and conditions are regulated by a state agency or the FCC, the regulations are available for your inspection. If there is any inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: _____

Attn: _____

New Address: _____

City: _____

State: _____ Country: _____

Zip: _____

Phone Number: _____

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 7526790
Invoice Date: 06/23/01
P. O. Number: X028721 & X002279

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
71.10	0.00	0.00	71.10	82.68	153.78

Payments received after 06/23/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance	$ 71.10	
Payments Received Through 06/23/01		
Adjustments to Previous Balance		
Total Balance Forward		$ 71.10
Current Charges		
Service Charges	$ 82.68	
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		$ 82.68

RECEIVED
2001 JUN 27 A 10:

Pay Total Amount Due by 07/17/01 to Avoid Late Fee

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
82.68	71.10	0.00	0.00	153.78

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	7526790	06/23/01	82.68	153.78	

If You Have Questions, Call Customer Care 1 405 440-1400 ☐ Check here for change of address (see reverse)

AT 01 014284 77537B 84 A**3DGT
STATE-DOH/CHILD ABUSE
ATTACCOUNTS PAYABLE
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000015378000008268752679028010700O

General Terms and Conditions

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The Term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. **YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.**

1. SERVICE.

a. Term/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid In Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any disputes must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rented Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement, in addition to all other remedies available to us. We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Records/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are uncollectable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

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4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rented Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of the vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or dama does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthoriz repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to termin Loss/Damage Protection if we determine that loss or damage of rented Pagers has been excessive. Upon advance notice, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochure any, as amended from time to time.

c. Your Responsibility for Rented Pager. If the rented Pager is not covered by Loss/Damage Protection and if you do not depo with us a sum covering the cost of any rental Pager, then in the event (i) any Pager rented from us is lost, stolen, destroy or damaged beyond repair, with or without your fault, or (ii) if you do not return the rental Pager in good condition to us up our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or rer charges for such Pager, plus the replacement cost of the rental Pager, as specified in this Agreement. Payments ma pursuant to this Agreement shall not in any way affect title to the rental Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you will give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

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"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, provic such repair is reasonable and necessary component parts are available. Maintenance does not include replacement of Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intentio abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

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The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended in time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER, FC INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAUS BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS. O LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING TH AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUCH LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NOT LIABLE FOR (i) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR AN EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (ii) TH INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT LIAB FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.

b. Indemnification. YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND AN UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YOU PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR SO NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND COS INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURVI TERMINATION OF THIS AGREEMENT.

c. No Warranties. WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCLA ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICUL PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND YI SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND AN STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURVI TERMINATION OF THIS AGREEMENT.

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You author our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic dial equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are fr released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited in U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your addre Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your not must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents directly indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises ma to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement sh be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms conditions are regulated by a state agency or the FCC, the regulations are available for your inspection; if there is inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: _____

Attn: _____

New Address: _____

City: _____

State: _____ Country: _____

Zip: _____

Phone Number: _____

RECEIVED
2001 AUG 30 P 4:17
FINANCIAL MANAGEMENT

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 7526790
Invoice Date: 06/23/01
P. O. Number: X028721 & X002279

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
71.10	0.00	0.00	71.10	82.68	153.78

Payments received after 06/23/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 71.10
Payments Received	
Total Balance Forward	**$ 71.10**

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-4712	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 559-5917	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 620-9425	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 620-9604	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 630-3444	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 630-3743	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 636-5771	DD with Extended Coverage	06/29/01 Thru 07/28/01	$ 3.95
(405) 636-8629	DD with Extended Coverage	06/29/01 Thru 07/28/01	$ 3.95
(405) 647-2312	DD with Extended Coverage	06/29/01 Thru 07/28/01	$ 3.95
(405) 647-6076	DD	05/31/01 Thru 06/28/01	$ 3.68
	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 660-7923	DD	06/29/01 Thru 07/28/01	$ 3.95

*** Continued on next page ***

General Terms and Conditions

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. **YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.**

1. SERVICE.

a. Terms/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, the Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. Service is available to your Pager when it is turned on and is within the operating range of our system. Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number; we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid In Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any disputes must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rental Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement, in addition to all other remedies available to us. We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Reports/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are undeliverable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 20 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rented Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of like vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or [illegible] does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthor[illegible] repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to term[illegible] Loss/Damage Protection if we determine that loss or damage of rented Pagers has been excessive. Upon advance notice in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection broch[illegible] any, as amended from time to time.

c. Your Responsibility for Rented Pager. If the rented Pager is not covered by Loss/Damage Protection and if you do not de[illegible] with us a sum covering the cost of any rented Pager, then in the event (i) any Pager rented from us is lost, stolen, disem[illegible] or damaged beyond repair, with or without your fault, or (ii) if you do not return the rented Pager in good condition to us [illegible] our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or [illegible] charges for such Pager, plus the replacement cost of the rented Pager, as specified in this Agreement. Payments [illegible] pursuant to this Agreement shall not in any way affect title to the rented Pager, which shall remain with us.

d. Title to Equipment. Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you w[illegible] give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

e. Maintenance for Your Rented Pager. Company will provide Maintenance (as defined in paragraph 5 below), and the fe[illegible] this is included in your Service charges.

5. MAINTENANCE.

"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, pro[illegible] such repair is reasonable and necessary component parts are available. Maintenance does not include replacement [illegible] Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intent[illegible] abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

If you request Maintenance for Pagers not rented from us, you agree to pay the required charges, and we agree to repa[illegible] Pager(s) when the need for repair arises from normal wear and tear and/or equipment defect or malfunction. We, in our [illegible] discretion, retain the right to deny Maintenance on any non-rental Pagers.

The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended [illegible] time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER, INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAU[illegible] BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS. [illegible] LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING [illegible] AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUC[illegible] LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NO[illegible] LIABLE FOR (i) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR [illegible] EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (ii[illegible] INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT L[illegible] FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.

b. Indemnification. YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND [illegible] UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YO[illegible] PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR S[illegible] NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND CO[illegible] INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SUR[illegible] TERMINATION OF THIS AGREEMENT.

c. No Warranties. WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCL[illegible] ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICU[illegible] PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND [illegible] SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND [illegible] STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SUR[illegible] TERMINATION OF THIS AGREEMENT.

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You authc[illegible] our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic di[illegible] equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are t[illegible] released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited i[illegible] U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your addr[illegible] Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your [illegible] must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give [illegible] notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents direc[illegible] indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which [illegible] only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises m[illegible] to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless [illegible] accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement s[illegible] be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may [illegible] amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms [illegible] conditions are regulated by a state agency or the FCC, the regulations are available for your inspection. If there is [illegible] inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: _____

Attn: _____

New Address: _____

City: _____

State: _____ Country: _____

Zip: _____

Phone Number: _____

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 7528790
Invoice Date: 06/23/01
P. O. Number: X028721 & X002279

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
71.10	0.00	0.00	71.10	82.68	153.78

Payments received after 06/23/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 690-0290	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 690-3767	DD with Extended Coverage	06/29/01 Thru 07/28/01	$ 3.95
(405) 690-4708	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 770-1192	DD with Extended Coverage	06/29/01 Thru 07/28/01	$ 3.95
(405) 770-3304	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 770-6946	DD	06/29/01 Thru 07/28/01	$ 3.95
(405) 800-6917	DD with Extended Coverage	06/29/01 Thru 07/28/01	$ 3.95
(405) 800-8277	Extra Access Number		$ 0.00
(918) 220-6504	DD	06/29/01 Thru 07/28/01	$ 3.95
(918) 220-6511	DD	06/29/01 Thru 07/28/01	$ 3.95
Total Current Activity			$ 82.68

General Terms and Conditions

This is an agreement ("Agreement") for wireless radio telecommunications services ("Service") between you and the affiliate of Metrocall which is licensed to provide Service in the area associated with your assigned pager number(s) ("Number"). The Term "Pager" means the wireless receiving equipment which is programmed with the Number. If so indicated, this is also an agreement for the rental and/or maintenance of Pagers. YOUR ACTIVATION AND/OR USE OF THE PAGER AND SERVICE IS YOUR CONSENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. IF YOU DO NOT AGREE WITH THESE TERMS AND CONDITIONS, DO NOT USE THE PAGER OR THE SERVICE AND NOTIFY US IMMEDIATELY TO CANCEL SERVICE.

1. SERVICE.

a. Term/Rates/Termination. The term of this Agreement for each Number begins on the date we activate Service for that Number. Your Service term, rates and conditions for each Number are described in the rate materials which you receive separately, all of which are a part of this Agreement. After the initial term, this Agreement will automatically renew for successive periods of the same term until terminated by either party. Notwithstanding the termination, you shall be responsible for service and rental charges for rented Pagers until the rented Pager is returned to us.

b. Availability/Interruption. *Service is available to your Pager when it is turned on and is within the operating range of our system.* Service is subject to transmission limitation or interruption, and any interruptions resulting from nonpayment of charges by you.

c. Use of Service/Equipment/Number. You agree not to use the Pager or Service for any unlawful or abusive purpose or in any way which damages our property or interferes with or disrupts our system or other users. Resale of Service is prohibited without prior contractual arrangements with us and any required regulatory approvals. You will comply with all laws while using the Service. You are responsible for ensuring that your Pager is compatible, as we determine in our sole discretion, with our Service and meets federal standards. You have no ownership rights to the Number, we may change your Number by giving you notice.

d. Fraud. If your Pager is stolen or Service is fraudulently used, you must immediately notify us. We have the right to interrupt or restrict Service to your number, without notice to you, if we suspect fraudulent or abusive activity. You agree to cooperate with us in any fraud prevention measures we prescribe. Failure to cooperate will result in your liability for all fraudulent usage.

2. CHARGES/PAYMENTS/DEFAULT.

a. Generally. You are responsible for paying all charges to your account for Service, equipment rental, Loss/Damage Protection and Maintenance. You are responsible for all charges (including, but not limited to, taxes, surcharges, fees, assessments, telecommunications fees, and/or recoveries) imposed on you or us as a result of use of the Service on your account, our providing Pager(s) to you, or the purchase of goods.

b. Billing and Payment. We will provide your bill in a format that we choose, which may change from time to time. Payment of all charges is due upon date specified on the invoice. Billing cycle and dates may change from time to time. When a billing cycle covers less than or more than one full month, we may make reasonable adjustments and prorations. If you have authorized payment by credit card, no additional notice or consent will be required for billings to that credit card or account.

c. Late Payments/Disputes. Time is of the essence for payment. Therefore, you agree to pay us a monthly $3 late fee on accounts with past due balances between $10 and $200, or for past due balances over $200, the late fee will be 1.5% per month of the unpaid balance. Acceptance of late or partial payments (even if marked "Paid in Full") shall not waive any of our rights to collect the full amount due under this Agreement. We may assess an additional fee in the amount of $20 for any check returned for nonpayment. Notice of any disputes must be in writing and received by us at our address within 30 days after receipt of invoice or you will waive any objection.

d. Default/Termination. If you fail to pay any amount owed to us by the due date, or if you breach any representation to us or fail to perform any of the promises you made in this Agreement, or if you have amounts still owing to us or an affiliate of ours from a prior account, or if you are subject to any proceeding under the Bankruptcy Code or similar laws, we may suspend or restrict Service, take possession of all rental Pagers (damages occasioned by such taking of possession are expressly waived by you) and/or terminate this Agreement, in addition to all other remedies available to us. We may require reconnection charges to renew Service after termination or suspension. Upon termination, you are responsible for paying all amounts and charges owing under this Agreement, including any applicable cancellation fee. You agree to pay all costs including attorneys' fees, collection costs, and court costs we incur in enforcing this Agreement through any appeal.

e. Deposits/Credit Reports/Balances. You authorize us to ask consumer reporting agencies or trade references to furnish us with employment and credit information, and you consent to our rechecking and reporting personal and/or business payment and credit history. We may require a deposit to establish or maintain Service. The deposit will be held as a partial guarantee of payment. It cannot be used by you to pay your bill or delay payment. Unless required by law, deposits may be mixed with other funds and will not earn interest. We may require you to increase your deposit at any time to reflect your estimated monthly charges based on actual usage or our reevaluation of your ability to pay. You may request that we reevaluate your credit worthiness on an annual basis, which may result in a partial or total refund of the deposit to you or credit to your account. If you default or this Agreement is terminated, we may, without notice to you, apply any deposit towards payment of charges due. After approximately 90 days following termination of this Agreement, any remaining deposit or other credit balance (other than the nonrefundable Loss/Damage Protection Charge) in excess of $5 will be returned without interest to you at your last known address. Unless you specifically request a refund, you agree any amounts under $5, as well as, amounts which are undeliverable, become our property.

f. Account Information. Any person able to provide your name, address, and the Number is authorized by you to receive information about your account, and to make changes to the account, including adding new Numbers and Pagers.

3. CHANGES TO OUR AGREEMENT.

We may change or modify this Agreement, including the rate materials, your Service plan and other Service features, upon advance notice. If you do not agree to the change, you may terminate this Agreement by giving us written notice within 20 days of the date we mail our notice. If you use the Service more than 20 days after we mail you notice of a change, you agree to that change. You may change Service features or Service plan by notifying us and paying our standard charges, and by complying with any other of our requirements to accomplish the change.

4. RENTAL OF PAGER(S).

a. Rental Charges. If you are renting the Pager, you agree to pay rent to us at the price and on the terms specified in this Agreement.

b. Loss/Damage Protection Charge. We may require a separate deposit if you are renting the Pager. Alternatively, you may pay a Loss/Damage Protection Charge in the amount specified in this Agreement. If you pay this Charge and a rental Pager is lost, stolen, destroyed or damaged beyond repair, your Pager will be replaced with a pager of like vintage and model based on equipment availability as determined by the Company in its sole discretion at the time, provided that such loss or damage does not arise from (i) you or your employees, agents or assigns negligence or intentional abuse or misuse, or (ii) unauthorized repairs. Any pre-paid Loss/Damage Protection Charge is nonrefundable. We, in our sole discretion, retain the right to terminate Loss/Damage Protection if we determine that loss or damage of rental Pagers has been excessive. Upon advance notice, we, in our sole discretion, retain the right to assess a minimum charge for any loss/damage claim made by you.

The terms and conditions of Loss/Damage Protection are further detailed in the current Loss/Damage Protection brochure, if any, as amended from time to time.

c. Your Responsibility for Rental Pager. If the rental Pager is not covered by Loss/Damage Protection and if you do not deposit with us a sum covering the cost of any rental Pager, then in the event (i) any Pager rented from us is lost, stolen, destroyed, or damaged beyond repair, with or without your fault, or (ii) if you do not return the rental Pager in good condition to us upon our request, you shall pay within five (5) days of request any unpaid Maintenance, as defined below in paragraph 5, or rental charges for such Pager, plus the replacement cost of the rental Pager, as specified in this Agreement. Payments made pursuant to this Agreement shall not in any way affect title to the rental Pager, which shall remain with us.

d. Title to Equipment. *Title to and ownership of all rented Pagers shall remain at all times in us. You agree that you will not* give away, sell, or encumber the rented Pagers or impair our title to and ownership of said Pagers.

e. Maintenance for Your Rental Pager. Company will provide Maintenance (as defined in paragraph 5 below), and the fee for this is included in your Service charges.

5. MAINTENANCE.

"Maintenance" is the repair or replacement (with a comparable pager of our choosing) of your Pager at our option, provided such repair is reasonable and necessary component parts are available. Maintenance does not include replacement of any Pager on account of loss or destruction beyond repair or for damage to the Pager arising from (i) negligence, or intentional abuse or misuse by you or your employees, agents or assigns, or (ii) unauthorized repairs.

If you request Maintenance for Pagers not rented from us, you agree to pay the required charges, and we agree to repair the Pager(s) when the need for repair arises from normal wear and tear and/or equipment defect or malfunction. We, in our sole discretion, retain the right to deny Maintenance on any non-rental Pagers.

The terms and conditions of Maintenance are further detailed in the current Maintenance brochure, if any, as amended from time to time.

6. PURCHASE OF EQUIPMENT.

If you purchase the Pager, you agree to purchase it "as is" from us at the specified price.

7. LIMITATIONS.

a. Limitation of Liability. WE ARE NOT LIABLE FOR ANY ACTS OR OMISSIONS OF ANOTHER SERVICE PROVIDER, FOR INFORMATION PROVIDED THROUGH YOUR PAGER, EQUIPMENT FAILURE OR MODIFICATION OR OTHER CAUSES BEYOND OUR REASONABLE CONTROL. WE ARE NOT LIABLE FOR SERVICE OUTAGES OF 24 HOURS OR LESS. OUR LIABILITY FOR ANY FAILURE OR MISTAKE SHALL IN NO EVENT EXCEED OUR SERVICE CHARGES DURING THE AFFECTED PERIOD. WE SHALL NOT BE LIABLE FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES SUCH AS LOST PROFITS EVEN IF WE HAVE BEEN INFORMED OF THE POSSIBILITY OF THOSE DAMAGES. WE SHALL NOT BE LIABLE FOR (i) INJURIES TO PERSONS OR PROPERTY ARISING FROM USE OF THE SERVICE, THE PAGER OR ANY EQUIPMENT USED IN CONNECTION WITH THE PAGER UNLESS CAUSED BY OUR SOLE NEGLIGENCE OR (ii) THE INSTALLATION OR REPAIR OF THE PAGER BY ANY PARTIES WHO ARE NOT OUR EMPLOYEES. WE ARE NOT LIABLE FOR ANY ACT ASSOCIATED WITH THE PROPER EXERCISE OF OUR RIGHTS UNDER THIS AGREEMENT.

b. Indemnification. YOU AGREE TO DEFEND, INDEMNIFY, AND HOLD US, OUR AFFILIATES AND AGENTS AND ANY UNDERLYING CARRIER, HARMLESS FROM CLAIMS OR DAMAGES RELATING TO THIS AGREEMENT OR YOUR PROMISE OR STATEMENT MADE IN IT AND USE OF THE PAGER OR SERVICE UNLESS DUE TO OUR SOLE NEGLIGENCE. YOU AGREE TO PAY OUR REASONABLE ATTORNEYS' AND EXPERT WITNESS FEES AND COSTS INCURRED IN ENFORCING THIS AGREEMENT THROUGH ANY APPEAL. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.

c. No Warranties. WE MAKE NO EXPRESS WARRANTY REGARDING THE SERVICE OR THE PAGER AND DISCLAIM ANY IMPLIED WARRANTY, INCLUDING ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. WE DO NOT AUTHORIZE ANYONE TO MAKE A WARRANTY OF ANY KIND ON OUR BEHALF AND YOU SHOULD NOT RELY ON ANY SUCH STATEMENT. WE ARE NOT THE MANUFACTURER OF THE PAGER AND ANY STATEMENT REGARDING IT SHOULD NOT BE INTERPRETED AS A WARRANTY. THIS PARAGRAPH SHALL SURVIVE TERMINATION OF THIS AGREEMENT.

8. MISCELLANEOUS.

a. Privacy. We shall not be liable for any lack of privacy which may be experienced while using the Service. You authorize our monitoring and recording of calls to us concerning your account or the Service. You consent to our use of automatic dialing equipment to contact you.

b. Assignment. We may assign all or part of our rights or duties under this Agreement without notice to you and we are then released from all liability. You may not assign this Agreement without our prior written consent.

c. Notices. Written notices to you shall be effective upon the earlier of receipt or 3 days following the date deposited in the U.S. Mail addressed to your address as kept in our files. You are responsible for notifying us of any changes in your address. Written notice to us shall be effective when directed to our Customer Care Department and received at our address. Your notice must specify your Number. Oral notices shall be deemed effective on the date reflected in our records. We will not give you notice of any subpoenas or court orders related to your account or use of Service unless required by law.

d. Severability. If any part of this Agreement is found invalid, the balance of the Agreement remains enforceable.

e. Entire Agreement/Facsimiles. These General Terms and Conditions, together with any other documents directly or indirectly made a part of these General Terms and Conditions represent the entire agreement between you and us, which may only be amended as described in this Agreement. This Agreement supersedes any inconsistent or additional promises made to you by any of our representatives, agents or dealers. No hand-marked changes on this Agreement will be valid unless we accept the changes in writing. Delivery by facsimile transmission (fax) of a signed copy or modification of this Agreement shall be effective as delivery of a manually signed original.

f. Governing Laws. This Agreement is subject to applicable federal laws, federal or state tariffs, if any, as they may be amended or enacted from time to time and the laws of the state associated with the Number. Where our Service, terms and conditions are regulated by a state agency or the FCC, the regulations are available for your inspection; if there is any inconsistency between this Agreement and those regulations, the regulations will amend this Agreement.

Change Of Address

Please Print

Name: ______________________________

Attn: ______________________________

New Address: ______________________________

City: ______________________________

State: ____________________ Country: ____________

Zip: ______________________________

Phone Number: ______________________________

STOP

Please be sure the address of the Payment Processing Center on the reverse side shows through the payment envelope window.

** AGENCY COPY ** SVC CHG: NC

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		219179

FOR AGENCY USE
WARRANT # 0015177 DATE: 12/27/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000240	88002	3922	939940000	11,899.41
000240	88002	3922		30,850.32

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR
$ 42,749.73
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

OFFICAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100 00	0000000	42,749.7

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
002		42,749.73
		OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUES CONTRACTS ONLY): 20010831

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
10/18/2001	OCT01	42,749.73

400AB12	000240NC97	3922AAAAAX	1,469.06
400AB12	000240TD97	3922AAAAAX	631.70
400BJ12	000240RV97	3922AAAAAX	832.37
[redacted]			
400CD12	000240PG97	3922AAAAAX	7,741.96
400CG12	000240PK97	3922AAAAAX	528.86
400CM12	000240TS97	3922AAAAAX	5,685.27
400EB12	000240VG97	3922AAAAAX	2,203.59
400EB12	000240W097	3922AAAAAX	10,944.52
400GY22	000240VM97	3922AAAAAX	12,016.94

J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached, provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 12/20/2001

Title Date

Agency, Bd or Div. Use

219175

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

Invoice Date: 18-Oct-01

Activity: 40 Community Health Services

Billing Period: August 01

Sub-Activity: 40002 County Health Departments

210-340-88181

Description	Percent	Amount
CPU Usage	0.00%	0.00
Direct Programming Services (See Attached Detail)	N/A	0.00
Allocation of Costs by FTE Distribution	56.01%	146,906.33
Total Monthly Charges		**146,906.33**

Reg Ck 2
219 177
~~219 179~~
219 180

Payment is due on or before: 18-Nov-01

RECEIVED
OCT 22 2001

15 - B

210 340

8818100 $AMT

DATE FUNDED 12/19/01

DATA BILL
AUG
FEI: 000-000-291
OBJECT CODE: 3922AAAAAX

REF CL:

1	25,502.94	
2	42,749.73	
3	78,653.66	12/19
TOTAL	146,906.33	

266KFX2	000240 NL97	88002	25,502.94
400AR12	000240 NC97	88002	1,469.06
400AR12	000240 TQ97	88002	631.70
400BI12	000240 RV97	88002	837.37
400BT12	000240 NW58	88002	337.88
400CD12	000240 P797	88002	352.58
400CD12	000240 PG97	88002	7,741.96
400CG12	000240 PK97	88002	528.86
400CM12	000240 TS97	88002	5,685.27
400EB12	000240 VG97	88002	2,203.59
400EB12	000240 W097	88002	10,944.52
400GY22	000240 VM97	88002	12,016.94
			42,749.73
192KFX2	010240 WN97	88002	1,821.64
192KFX2	010240 WC97	88002	631.70
192KFX2	010240 W097	88002	60,466.64
192KFX2	010240 QC97	88002	998.96
192CM12	010240 TS97	88002	2,526.79
192KDX2	010240 NG97	88002	10,298.13
192KFX2	010240 NG97	88002	1,909.80
			78,653.66

** AGENCY COPY ** SVC CHE: NC

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		219157

FOR AGENCY USE
WARRANT # 0015174 DATE: 12/27/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000240	88002	3922	939940000	18,455.08
000240	88002	3922		26,410.65

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address _____

FOR
$ 44,865.73
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

OFFICAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100	000000000	44,865.7

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
002		44,865.73

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010930

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
11/14/2001	NOV01	44,865.73

```
400AB12 000240NC97 3922AAAAAX     1,561.78
400AB12 000240TD97 3922AAAAAX       662.96
400BI12 000240RV97 3922AAAAAX       878.81
[illegible]
400CD12 000240PG97 3922AAAAAX     8,125.17
400CG12 000240PK97 3922AAAAAX       555.04
400CM12 000240TS97 3922AAAAAX     5,966.68
400EB12 000240VG97 3922AAAAAX     2,312.67
400EB12 000240W097 3922AAAAAX    11,486.24
400GY22 000240VM97 3922AAAAAX    12,611.74

J/E XREF:
```

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 12/20/2001

Title Date

Agency, Bd or Div. Use

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

Invoice Date: 14-Nov-01

Activity: 40 Community Health Services **Billing Period: September 01**

Sub-Activity: 40002 County Health Departments **210-340-88181**

Description	Percent	Amount
CPU Usage	0.00%	0.00
Direct Programming Services (See Attached Detail)	N/A	0.00
Allocation of Costs by FTE Distribution	58.23%	154,117.71
Total Monthly Charges		**154,117.71**

219 154
~~219 157~~
219 160

Payment is due on or before: 14-Dec-01

15 - B

210 340

8818100 $AMT

DATE FUNDED 12/19/01

DATA BILL
SEPT
FEI: 000-000-291
OBJECT CODE: 3922AAAAAX

REF CL:

1	26,765.25	
2	44,865.73	
3	82,546.73	
TOTAL	154,177.71	12/19

266KFX2	000240 NL97	88002	26,765.25 ✓
400AR12	000240 NC97	88002	1,541.78 ✓
400AR12	000240 TQ97	88002	662.96 ✓
400BI12	000240 RV97	88002	878.81 ✓
400BT12	000240 NW68	88002	354.61 ✓
400CD12	000240 P797	88002	370.03 ✓
400CD12	000240 PG97	88002	8,125.17 ✓
400CG12	000240 PK97	88002	555.04 ✓
400CM12	000240 TS97	88002	5,966.68 ✓
400EB12	000240 VG97	88002	2,312.67 ✓
400EB12	000240 W097	88002	11,486.24 ✓
400GY22	000240 VM97	88002	12,611.74 ✓
			44,865.73
192KFX2	010240 WN97	88002	1,911.80
192KFX2	010240 WC97	88002	662.96
192KFX2	010240 W097	88002	63,459.54
192KFX2	010240 QC97	88002	1,048.41
192CM12	010240 TS97	88002	2,651.86
192KDX2	010240 NG97	88002	10,807.86
192KFX2	010240 NG97	88002	2,004.30
			82,546.73

** AGENCY COPY ** SVC CHE: NC

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		219140

FOR AGENCY USE
WARRANT # 0015472 DATE: 01/03/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000240	88002	3922	939940000	6,387.19
000240	88002	3922		9,140.57

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR
$ 15,527.76
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

OFFICAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100	000000000	.0

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
002		15,527.76
		OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010731

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
09/14/2001	SEP01	15,527.76

400AR12 000240NC97 3922AAAAAX 533.60
400AR12 000240TQ97 3922AAAAAX 220.45
400BY12 000240RV97 3922AAAAAX 304.15
[illegible]
400CD12 000240PF97 3922AAAAAX 128.09
400CD12 000240PG97 3922AAAAAX 2,812.07
400CG12 000240PK97 3922AAAAAX 192.10
400CM12 000240TS97 3922AAAAAX 2,065.03
400EB12 000240VG97 3922AAAAAX 800.40
400EB12 000240W097 3922AAAAAX 3,975.32
400GY22 000240VM97 3922AAAAAX 4,364.85

J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 12/20/2001

Title Date

Agency, Bd or Div. Use

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

Invoice Date: 14-Sep-01

Activity: 40 **Community Health Services** **Billing Period: July 01**

Sub-Activity: 40002 **County Health Departments** **210-340-88181**

Description	Percent	Amount
CPU Usage	0.00%	0.00
Direct Programming Services (See Attached Detail)	N/A	0.00
Allocation of Costs by FTE Distribution	54.06%	53,360.04
Total Monthly Charges		**53,360.04**

H of Ed
219 139
219 140
219 141

Payment is due on or before: 30-Sep-01

15 - B

210 340

8818100 $AMT

DATE FUNDED 12/19/01

DATA BILL
JULY
FEI: 000-000-291
OBJECT CODE: 3922AAAAAX

REF CL:

1	9,263.30	
2	15,527.76	
3	28,568.98	
TOTAL	53,360.04	12/19

266KFX2	000240 NL97	88002	9,263.30
400AR12	000240 NC97	88002	533.60
400AR12	000240 TQ97	88002	229.45
400BI12	000240 RV97	88002	304.15
400BT12	000240 NW58	88002	122.73
400CD12	000240 P797	88002	128.06
400CD12	000240 PG97	88002	2,812.07
400CG12	000240 PK97	88002	192.10
400CM12	000240 TS97	88002	2,065.03
400EB12	000240 VG97	88002	800.40
400EB12	000240 W097	88002	3,975.32
400GY22	000240 VM97	88002	4,364.85
			15,527.76
192KFX2	010240 WN97	88002	661.66
192KFX2	010240 WC97	88002	229.45
192KFX2	010240 W097	88002	21,962.99
192KFX2	010240 QC97	88002	362.85
192CM12	010240 TS97	88002	917.79
192KDX2	010240 NG97	88002	3,740.54
192KFX2	010240 NG97	88002	693.70
			28,568.98

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	210002

FOR AGENCY USE
WARRANT # 7335754 DATE: 10/08/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35006	5511	000000000	1,728.00

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

2
1
0
0
0
2

FOR
$ 1,728.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
008		1,728.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010831

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
09/01/2001	092001	1,728.00

THIS SPACE FOR AGENCY USE

400BT12 000235NW97 5511AAAAAX 1728.00

J/E XREF: 020278

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

10/03/2001
Date

Agency, Bd or Div. Use

21002

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

RECEIVED
SEP 05 2001
OTTAWA COUNTY HEALTH DEPT.

INVOICE

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 9/1/01

Billing Period: 8/1/01 thru 8/31/01

Purchase Order #: X041428

CONTRACTOR Representative:

Bob Walker, Superintendent

918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	108	Hour	Teachers Aides - reading and math activities and assistance	8.00	864.00
002	108	Hour	Teachers Aides - speech language remediation	8.00	864.00
003		Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	
004		Monthly	Fringe Benefits (Health Insurance)	198.42	
			736021187 (08)		
			X041428 000235NW97	**Total Amount**	$1,728.00 ✓
			008 4000372		
			35005 5511 AX		

Total number of students served during this billing period: 90

INVOICE APPROVED 1030 DATE

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached

9/10/01

SEP 10

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Peggy Tharp

Date	001 Hours	002 Hours	003 Hours	Total hours
8/24/01	4	4		8
8/27/01	4	4		8
8/28/01	4	4		8
8/29/01	4	4		8
8/30/01	4	4		8
8/31/01	4	4		8

Total Time Sheet Hours	48

Employee signature: Peggy Tharp **Date:** 8-31-01

Supervisor signature: Kimberly J. Pace **Date:** 8-31-01 SEP 10

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: JoAnn Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
8/13/01	4	4		8
8/14/01	4	4		8
8/15/01	4	4		8
8/16/01	4	4		8
8/17/01	4	4		8
8/20/01	4	4		8
8/21/01	4	4		8
8/22/01	4	4		8
8/23/01	4	4		8
8/24/01	4	4		8
8/27/01	4	4		8
8/28/01	4	4		8
8/29/01	4	4		8
8/30/01	4	4		8
8/31/01	4	4		8

Total Time Sheet Hours	120

Employee signature: JoAnn Roberts **Date:** 8-31-01

Supervisor signature: Kimberly D. Pace **Date:** 8-31-01

SEP 10

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Alice Wilkendorf

Date	001 Hours	002 Hours	003 Hours	Total hours
8/24/01	4	4		8
8/27/01	4	4		8
8/28/01	4	4		8
8/29/01	4	4		8
8/30/01	4	4		8
8/31/01	4	4		8

Total Time Sheet Hours 48

Employee signature: Alice M. Wilkendorf **Date:** 8/31/01

SEP 10

Supervisor signature: Kimberly D. Pace **Date:** 8/31/01

Maxwell, Ronney

From: Maxwell, Ronney
Sent: Thursday, September 27, 2001 11:22 AM
To: Hicks, Tina R.
Subject: PICHER-CARDIN PUBLIC SCHOOL X041428

Importance: High

This P.O. does not end until 09/30/01, there has not been any funding added for 2002.

Please advise.

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Peggy Tharp

Date	001 Hours	002 Hours	003 Hours	Total hours
8/24/01	4	4		8
8/27/01	4	4		8
8/28/01	4	4		8
8/29/01	4	4		8
8/30/01	4	4		8
8/31/01	4	4		8

Total Time Sheet Hours 48

Employee signature: Peggy Tharp **Date:** 8-31-01

Supervisor signature: Kimberly D. Pace **Date:** 8-31-01 SEP 10

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: JoAnn Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
8/13/01	4	4		8
8/14/01	4	4		8
8/15/01	4	4		8
8/16/01	4	4		8
8/17/01	4	4		8
8/20/01	4	4		8
8/21/01	4	4		8
8/22/01	4	4		8
8/23/01	4	4		8
8/24/01	4	4		8
8/27/01	4	4		8
8/28/01	4	4		8
8/29/01	4	4		8
8/30/01	4	4		8
8/31/01	4	4		8

Total Time Sheet Hours	120

Employee signature: JoAnn Roberts **Date:** 8-31-01

Supervisor signature: Kimberly D. Pace **Date:** 8-31-01

SEP 10

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Alice Wilkendorf

Date	001 Hours	002 Hours	003 Hours	Total hours
8/24/01	4	4		8
8/27/01	4	4		8
8/28/01	4	4		8
8/29/01	4	4		8
8/30/01	4	4		8
8/31/01	4	4		8

Total Time Sheet Hours	48

Employee signature: Alice M. Wilkendorf **Date:** 8/31/01

SEP 10

Supervisor signature: Kimberly D. Pace **Date:** 8/31/01

Maxwell, Ronney

From: Maxwell, Ronney
Sent: Thursday, September 27, 2001 11:22 AM
To: Hicks, Tina R.
Subject: PICHER-CARDIN PUBLIC SCHOOL X041428

Importance: High

This P.O. does not end until 09/30/01, there has not been any funding added for 2002.

Please advise.

OSF FORM 15A
Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X077835	207385

FOR AGENCY USE
WARRANT # 7254784 DATE: 09/17/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35006	3312	939940000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2 0 7 3 8 5

FOR
$ 195.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to
_____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
005		195.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010902

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
08/14/2001	443160	195.00

THIS SPACE FOR AGENCY USE

400BT12 000235NW97 3312AAAAAX 195.00

J/E XREF: 020277

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

09/07/2001

Title Date

Agency, Bd or Div. Use

The KBlack Connection

Black Inc. CopySolutions Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

207385

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

SHIP TO

[illegible]	[illegible]	[illegible]	SHIPPING NO	SHIPPING DATE	[illegible]

HIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
			[illegible]					
			[illegible]		[illegible]			135.
			[illegible]					
			[illegible]					
			[illegible]					
			[illegible]	7306745 78 09				
								135.

XC77535 — 000135JUW97

Y — 005 — 400KST12

31006 — 3312 AX

CLAIM ENTERED

9-4-01

INVOICE APPROVED

09-07-2001

Please show INVOICE and ACCOUNT # on remittance

135.

MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
SUBJECT TO A 15% RESTOCKING CHARGE

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X077835	204035

FOR AGENCY USE
WARRANT # 7120826 DATE: 08/09/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35006	3312	932000000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2
0
4
0
3
5

FOR
$ 195.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
004		195.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010801

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
07/11/2001	438876	195.00

THIS SPACE FOR AGENCY USE

400BT12 000235NW97 3312AAAAAX 195.00

J/E XREF: 022170

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

08/03/2001

Title Date

Agency, Bd or Div. Use

The RKBlack Connection

RK Black Inc COPY SOLUTIONS Marathon

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

405 943-9801

204035

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
438876	NET 10

SHIP VIA:

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

ACCOUNT #	PURCHASE ORDER NO	SALES PERSON	SHIPPING NO	SHIPPING DATE	INVOICE DATE
2716868	T072445	OK HOUSE ACCOUN		7/11/01	7/11/01

ORD.	SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
				* MAINTENANCE CONTRACT NO. 18330					
				BILLING PERIOD FROM 8/2/01 THROUGH 9/1/01					
1	1		EA	AFICIO COLOR 3006	RICOH EPG	195.00		195.00	195.00
				SERIAL NO. 0100100116					
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
				DOES NOT INCLUDE SUPPLIES. RCV					
				CMI 04 05/01 AR					
						SUBTOTAL			195.00
						FREIGHT			.00
						SALES TAX			.00

CC 78535 CCO 2354447

CCY 400BT12

3312.1X

Main Entered RECEIVED

INV Funded By Date

7306745 26

* 1 PER MONTH (1 PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
* RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
* RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance ▶ 195.00

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X077835	202844

FOR AGENCY USE
WARRANT # 7069194 DATE: 07/25/2001

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2 0 2 8 4 4

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35006	3312	000000000	195.00

FOR
$ 195.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
003		195.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010701

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
06/12/2001	435063	195.00

THIS SPACE FOR AGENCY USE

400BT12 000235NW97 3312AAAAAX 195.00

J/E XREF: 022171

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

07/23/2001
Date

Agency, Bd or Div. Use

The KBlack Connection

Black Inc. COPYSOLUTIONS Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

202844

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
435063	NET 10

SHIP VIA:

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK [illegible]

	PURCHASE ORDER NO	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
6868	T072445	OK HOUSE ACCOUN		6/12/01	6/12/01

SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
			X MAINTENANCE CONTRACT NO. 18330					
			BILLING PERIOD FROM 7/2/01 THROUGH 8/1/01					
1		EA	AFICIO COLOR 3006	RICOH EPG	195.00		195.00	195.0
			SERIAL NO. 0100100116					
			SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
			DOES NOT INCLUDE SUPPLIES. ROV					
			OMI 04/05/01 AR					
					SUBTOTAL			195.0
					FREIGHT			.0
					SALES TAX			.0
					Please show INVOICE and ACCOUNT # on remittance			195.0

X071835 — PO# or CT#
000235 [illegible] — Account Number
/ / 003 — Complete-Partial
400[illegible] — Fund Number
31006 — Sub-Activity
3312AX — Object Code
/ / / — Math Entered
Claim Number
[illegible] — Inv Funded By
7-17-4 — Date
07-23-2001

Pd 730674578

MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
SUBJECT TO A 15% RESTOCKING CHARGE

Maxwell, Ronney

From: Maxwell, Ronney
Sent: Friday, June 29, 2001 12:30 PM
To: Wilson, Linda
Subject: R.K. Black T072445

Did this P.O. for Ottawa County get renewed.

Thanks

Maxwell, Ronney

From: Murphy, Romain
Sent: Friday, June 29, 2001 5:21 PM
To: Maxwell, Ronney
Subject: RE: R.K. Black T072445

It was renewed for 6 months and will be renewed for 1 year beginning Sept 1, 2001. (see Sonya Fouquet) for details

-----Original Message-----
From: Maxwell, Ronney
Sent: Friday, June 29, 2001 1:47 PM
To: Murphy, Romain
Subject: FW: R.K. Black T072445

-----Original Message-----
From: Wilson, Linda
Sent: Friday, June 29, 2001 1:36 PM
To: Maxwell, Ronney
Subject: RE: R.K. Black T072445

You will need to contact Romain Murphy about this. She nows handles P.O.'s for Ottawa County.

-----Original Message-----
From: Maxwell, Ronney
Sent: Friday, June 29, 2001 12:30 PM
To: Wilson, Linda
Subject: R.K. Black T072445

Did this P.O. for Ottawa County get renewed.

Thanks

** AGENCY COPY ** SVC CHE: TN

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		122614

FOR AGENCY USE
WARRANT # 0018295 DATE: 02/06/2001

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR
$ 260.26
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	88042	3922	932350000	260.26
000135	88042	3922		260.26

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $ 260.26
	YES	OSF-AUDITED BY

OFFICIAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100	000000000	520.5

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
12/12/2000	11302000	260.26
		.00

400AT11 000135TN0A 3922AAAAAX 260.26
400BT11 000135NW0A 3922AAAAAX 260.26

J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

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Agency's Approving Officer 02/01/2001

Title Date

Agency, Bd or Div. Use

122614

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

Invoice Date: 12-Dec-00

Activity: 35 Personal Health **Billing Period: November 00**

Sub-Activity: 42000 Child & Adolescent Health **210-340-88181**

Description	Percent	Amount
CPU Usage	0.49%	171.83
Direct Programming Services	N/A	0.00
Allocation of Costs by FTE Distribution	9.48%	25,854.08
Total Monthly Charges		**26,025.91**

Split Fund

191 $25,505.39 Cl# 122613
400 520.52 Cl# 122614
Total $26,025.91

Payment is due on or before: 15-Jan-01

OSDH DATA BILLING
FUNDING SHEETS

BILLING PERIOD: Nov-00

ACTIVITY: 35

SUB-ACTIVITY: 42000

AMOUNT OF BILLING: 26,025.91

PROGRAM	FUND	ACCOUNT	SUB-ACT	OBJ CODE	FTE %	AMOUNT	
GUIDANCE	191KDX1	010135NG0A	88042	3922AAAAAX	69%	17,957.88	SJF
PEDS	191AR11	010135NC0A	88042	3922AAAAAX	18%	4,684.66	SE
ADOLESCENT	191KDX1	010135NK0A	88042	3922AAAAAX	5%	1,301.30	SE
ABSTINENCE	400AT11	000135TN0A	88042	3922AAAAAX	1%	260.26	SE
COMPREHENSIVE	191AR11	010135NA0A	88042	3922AAAAAX	6%	1,561.55	SE
BCCSSE	400BT11	000135NW0A	88042	3922AAAAAX	1%	260.26	SJF
				TOTAL		26,025.91	

** AGENCY COPY ** SVC CHE: TN

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA

Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		122631

FOR AGENCY USE
WARRANT # 0018297 DATE: 02/06/2001

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR $ 155.11

AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	88042	3922	93235000	155.11
000135	88042	3922		155.12

1 2 2 6 3 1

OFFICIAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100	00000000	310.2

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $ 155.11
	YES	OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
12/07/2000	10312000	155.11
		.00

400AT11 000135TN0A 3922AAAAAX 155.11
400BT11 000135NW0A 3922AAAAAX 155.12

J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

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Agency's Approving Officer 02/01/2001

Title Date

Agency, Bd or Div. Use

122631

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

Invoice Date: 07-Dec-00

Activity: 35 Personal Health **Billing Period: October 00**

Sub-Activity: 42000 Child & Adolescent Health **210-340-88161**

Description	Percent	Amount
CPU Usage	0.56%	198.56
Direct Programming Services	N/A	0.00
Allocation of Costs by FTE Distribution	9.65%	15,312.66
Total Monthly Charges		**15,511.21**

Split Claim

191 $15,200.98 Cl #122628
400 310.23 Cl # 122631
Total $15,511.21

Payment is due on or before: 15-Jan-01

OSDH DATA BILLING
FUNDING SHEETS

BILLING PERIOD: Oct-00

ACTIVITY: 35

SUB-ACTIVITY: 42000

AMOUNT OF BILLING: 15,511.21

PROGRAM	FUND	ACCOUNT	SUB-ACT	OBJ CODE	FTE %	AMOUNT
GUIDANCE	191KDX1	010135NG0A	88042	3922AAAAAX	69%	10,702.73 SJF
PEDS	191AR11	010135NA0A SE	88042	3922AAAAAX	18%	2,792.02 SE
ADOLESCENT	191KDX1	010135NK0A	88042	3922AAAAAX	5%	775.56 SE
ABSTINENCE	400AT11	000135TN0A	88042	3922AAAAAX	1%	155.11 SE
COMPREHENSIVE	191AR11	010135NA0A	88042	3922AAAAAX	6%	930.67 SE
BCCSSE	400BT11	000135NW0A	88042	3922AAAAAX	1%	155.12 SJF
				TOTAL		15,511.21

** AGENCY COPY ** SVC CHE: TN

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
210	340		137283

FOR AGENCY USE
WARRANT # 0029579 DATE: 06/22/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000000	00000	8181	932350000	277.49

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR
$ 277.49
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

OFFICAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100		277.4

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $ 277.49
	YES	OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010228

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
04/20/2001	FEBRUARY	277.49

400AT11 000135TN0A 3922AAAAAX 138.74
400BT11 000135NW0A 3922AAAAAX 138.75
J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

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Agency s Approving Officer 06/18/2001

Title Date

Agency, Bd or Div. Use

Cl# 137283

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

Invoice Date: 20-Apr-01

Activity: 35 Personal Health

Billing Period: February 01

Sub-Activity: 42000 Child & Adolescent Health

210-340-88181

Description	Percent	Amount
CPU Usage	0.08%	27.96
Direct Programming Services (See Attached Detail	N/A	0.00
Allocation of Costs by FTE Distribution	9.02%	13,846.52
Total Monthly Charges		**13,874.49**

Split Claim

PURCHASE DOCUMENT ✓ — ACCOUNT NO. 000135
COMPLETE ✓ PARTIAL — FUND NO. 210
SUB ACTIVITY 42000 — OBJECT CODE [redacted]
MATH ✓ ENTERED — CLAIM NUMBER [redacted]-X
INVOICE APPROVED — DATE 06-18-2001

Cl#137283
$277.49

PURCHASE DOCUMENT ✓ — ACCOUNT NO. 000135
COMPLETE ✓ PARTIAL — FUND NO. 210
SUB ACTIVITY 42000 — OBJECT CODE [redacted]-X
MATH ✓ ENTERED — CLAIM NUMBER
INVOICE APPROVED — DATE 06-18-2001

Cl#137280
~~$13,870.00~~
$13,597.00

PROCUREMENT
MAY 30 2001
RECEIVED

Payment is due on or before: 15-May-01

OSDH DATA BILLING
FUNDING SHEETS

BILLING PERIOD: Feb-01

ACTIVITY: 35

SUB-ACTIVITY: 42000 Split Claim

AMOUNT OF BILLING: 13,874.49

PROGRAM	FUND	ACCOUNT	SUB-ACT	OBJ CODE	FTE %	AMOUNT
GUIDANCE	191KDX1	010135NG0A	88042	3922AAAAAX	69%	9,573.40
PEDS	~~191AR11~~	~~010135NC0A~~	~~88042~~	3922AAAAAX	18%	~~2,497.41~~ 3,191.13
ADOLESCENT	191KDX1	010135NK0A	88042	3922AAAAAX	5%	~~693.72~~
ABSTINENCE	400AT11	000135TN0A	88042	3922AAAAAX	1%	138.74
COMPREHENSIVE	191AR11	010135NA0A	88042	3922AAAAAX	6%	832.47
BCCSSE	400BT11	000135NW0A	88042	3922AAAAAX	1%	138.75
				TOTAL		13,874.49

Split Claim 0-291

191 13,597.00 Cl# 137280

400 277.49 Cl# 137283

Total 13,874.49

** AGENCY COPY ** SVC CHG: NC

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA

Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		123271

FOR AGENCY USE
WARRANT # 0018775 DATE: 02/12/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	88042	3922	939940000	191.28

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
	YES	3,825.61

OSF-AUDITED BY

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR
$ 3,825.61
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

OFFICIAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100		3,825.61

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY)

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
01/25/2001	ECEMBER	3,825.61
		.00
		.00

400AR11 000135NC0A 3922AAAAAX 3443.05
400AT11 000135TN0A 3922AAAAAX 191.28
400BT11 000135NW0A 3922AAAAAX 191.28

J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

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Agency's Approving Officer

Title

Date 02/07/2001

Agency, Bd or Div. Use

133271 d

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

RECEIVED
2001 FEB -5 FINANCIAL MANAGEMENT

Invoice Date: 25-Jan-01

Activity: 35 Personal Health **Billing Period: December 00**

Sub-Activity: 42000 Child & Adolescent Health **210-340-88181**

Description	Percent	Amount
CPU Usage	0.72%	254.52
Direct Programming Services	N/A	0.00
Allocation of Costs by FTE Distribution	9.46%	18,873.53
Total Monthly Charges		**19,128.04**

Funding Attached

Payment is due on or before: 15-Feb-01

OSDH DATA BILLING
FUNDING SHEETS

BILLING PERIOD: DECEMBER

ACTIVITY: 35

SUB-ACTIVITY: 42000

AMOUNT OF BILLING: 19,128.04

PROGRAM	FUND	ACCOUNT	SUB-ACT	OBJ CODE	FTE %	AMOUNT
GUIDANCE	191KDX1	010135NG0A	88042	3922AAAAAX	69%	13,198.35 SE
PEDS	~~191AR11~~ 400AR11	~~010135NC0A~~ 000135NC0A SE	88042	3922AAAAAX	18%	3,443.05 SE
ADOLESCENT	191KDX1	010135NK0A	88042	3922AAAAAX	5%	956.40 SE
ABSTINENCE	400AT11	000135TN0A	88042	3922AAAAAX	1%	191.28 SE
COMPREHENSIVE	191AR11	010135NA0A	88042	3922AAAAAX	6%	1,147.68 SE
BCCSSE	400BT11	000135NW0A	88042	3922AAAAAX	1%	191.28 SE
				TOTAL		19,128.04

191 123272 15,302.43

400 123271 3,825.61

** AGENCY COPY ** SVC CHG: NC

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		129709

FOR AGENCY USE
WARRANT # 0023543 DATE: 04/11/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	88042	3922	939940000	5,909.11
000135	88042	3922		311.00

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
	YES	5,909.10
		OSF-AUDITED BY

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR
$ 5,909.10
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

OFFICAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
210	340

Receipt	CFDA	Amount
8818100	000000000	6,220.1

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010131

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT	
03/07/2001	JANUARY,2001	.00	400AR11 000135NC0A 3922AAAAAX 5598.10
		.00	400AT11 000135TN0A 3922AAAAAX 311.01
		.00	400BT11 000135NW0A 3922AAAAAX 311.00

J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

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Agency's Approving Officer

Title

Date 04/09/2001

Agency, Bd or Div. Use

129709

Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

Invoice Date: 07-Mar-01

Activity: 35 Personal Health **Billing Period: January 01**

Sub-Activity: 42000 Child & Adolescent Health **210-340-88181**

Description	Percent	Amount
CPU Usage	0.20%	71.26
Direct Programming Services (See Attached Detail	N/A	0.00
Allocation of Costs by FTE Distribution	9.47%	31,029.30
Total Monthly Charges		**31,100.56**

Split Claim

Cl# 129708 $24,880.45
Cl# 129709 6220.11
31,100.56

Payment is due on or before: 31-Mar-01

OSDH DATA BILLING
FUNDING SHEETS

BILLING PERIOD: Jan-01

ACTIVITY: 35

SUB-ACTIVITY: 42000

AMOUNT OF BILLING: 31,100.56

PROGRAM	FUND	ACCOUNT	SUB-ACT	OBJ CODE	FTE %	AMOUNT
GUIDANCE	191KDX1	010135NG0A	88042	3922AAAAAX	69%	21,459.39 ✓
PEDS	~~191AR11~~ 400ARU	~~010135NG0A~~ 000135NC0A	88042	3922AAAAAX	18%	5,598.10
ADOLESCENT	191KDX1	010135NK0A	88042	3922AAAAAX	5%	1,555.03 ✓
ABSTINENCE	400AT11	000135TN0A	88042	3922AAAAAX	1%	311.01
COMPREHENSIVE	191AR11	010135NA0A	88042	3922AAAAAX	6%	1,866.03 ✓
BCCSSE	400BT11	000135NW0A	88042	3922AAAAAX	1%	311.00
				TOTAL		31,100.56

S. Easton

Split Claim

191 $ 24,860.45

400 [redacted] 6,220.11

$ 31,100.56

Cl# 129708 ✓
Cl# 129709 ↓

** AGENCY COPY ** , SVC CHF: NC

OSF FORM 15B
(Revised 1992)

STATE OF OKLAHOMA
Inter/Intra Payment

FUND	AGENCY	ORDER NO.	CLAIM NO.
210	340		201334

FOR AGENCY USE
WARRANT # 0000517 DATE: 07/12/2001

CLAIM OF:
SPECIAL FUND 210
736017987

P.O.Address

FOR
$ 4,863.29
AGAINST

Agency, Board, Comm., Dept. Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000000	00000	8181	93994000	4,863.29

OFFICAL DEPOSITORY
DEPOSIT REGISTER

FUND	AGENCY
240	340

Receipt	CFDA	Amount
8818100		4,863.29

Enter the partial payment or final payment number if claim is to Be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $ 4,863.29
	YES	OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

THIS SPACE FOR AGENCY USE

INVOICE DATE	INVOICE NO.	AMOUNT
04/20/2001	MAR 01	4,863.29

400AR11 000135NC0A 3922AAAAAX 4,376.96
400AT11 000135TN0A 3922AAAAAX 243.16
400BT11 000135NW0A 3922AAAAAX 243.17
J/E XREF:

VENDOR: DATA MANAGEMENT
ADDRESS: DO NOT MAIL ... FOR DEPOSIT BY
ADDRESS: OSDH
CITY/ST/ZIP:

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached, provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must approved by the architect or engineer in charge of the project. Receiving reports may be susubmitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 07/09/2001

Title Date

Agency, Bd or Div. Use

PAT

20133 4

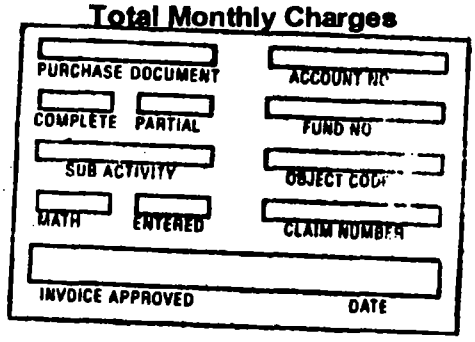
Special Fund 210
Oklahoma State Department of Health
Data Management
Intra-Agency Reimbursement

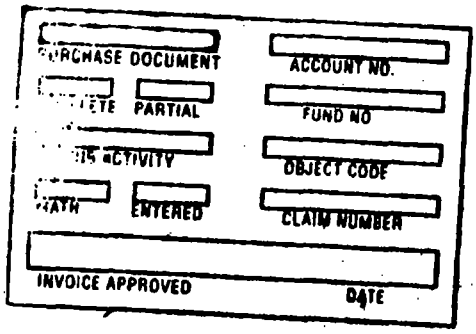
Activity: 35 **Personal Health**
Sub-Activity: 42000 **Child & Adolescent Health**

Invoice Date: 20-Apr-01
Billing Period: March 01
210-340-88181

Description	Percent	Amount
CPU Usage	0.03%	9.98
Direct Programming Services (See Attached Detail	N/A	0.00
Allocation of Costs by FTE Distribution	8.96%	24,306.46
		24,316.44

Total Monthly Charges





0-291

201333
201334

Payment is due on or before: **15-May-01**

OSDH DATA BILLING
FUNDING SHEETS

BILLING PERIOD: Mar-01

ACTIVITY: 35

SUB-ACTIVITY: 42000

AMOUNT OF BILLING: 24,316.44

191YVX1 030135NEUA 88041

PROGRAM	FUND	ACCOUNT	SUB-ACT	OBJ CODE	FTE %	AMOUNT
GUIDANCE	~~191KDX1~~	~~010136NG0A~~	~~88042~~	3922AAAAAX	69%	16,778.34
PEDS	~~400AR11~~ ~~191AR11~~	~~000135NC0A~~ 010135NC0A	88042	3922AAAAAX	18%	4,376.96
ADOLESCENT	191KDX1	010135NK0A	88042	3922AAAAAX	5%	1,215.82
ABSTINENCE	400AT11	000135TN0A	88042	3922AAAAAX	1%	243.16
COMPREHENSIVE	191AR11	010135NA0A	88042	3922AAAAAX	6%	1,458.99
BCCSSE	400BT11	000135NW0A	88042	3922AAAAAX	1%	243.17
				TOTAL		24,316.44

0-291

Split Claim:

191 $19,453.15

400 4,863.29

Total 24,316.44

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X054707	122182

FOR AGENCY USE
WARRANT # 7688599 DATE: 01/31/2001

CLAIM OF:
HCFA LABORATORY PROGRAM
520883104

FOR
$ 150.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3138	937770000	150.00

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	150.00
001	YES	OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010115

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
01/15/2001	37D0968929	150.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3138AAAAAX 150.00

J/E XREF:

VENDOR: HCFA LABORATORY PROGRAM
ADDRESS: PO BOX 105422
ADDRESS:
CITY/ST/ZIP: ATLANTA GA 303485422

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

01/29/2001

Title Date

Agency, Bd or Div. Use

122182

01/02/01 TUE 12:20 FAX 1 918 540 2486 OTTAWA HEALTH DP 002

CLIA USER FEE REMITTANCE
(SEE BACK OF FORM FOR SPECIAL INSTRUCTIONS)

CLIA IDENTIFICATION NUMBER	CERTIFICATE DUE	COMPLIANCE DETERMINATION DUE	ADJUSTMENT DUE	TOTAL DUE
37D0968929	150.00	.00	.00	150.00 ✓

ACTIVITY: 24 - REBILL
630

DATE DUE: 01/15/2001

FORM HCFA-35 (5-92)

NAME AND ADDRESS OF LABORATORY

OTTAWA COUNTY HEALTH DEPARTMENT
1930 N ELM
MIAMI OK 74354-0000

INDICATE ANY CHANGES IN NAME OR ADDRESS

0968929000000000000011290000150000000000000000150000

520883104

X054707	000195NW9V
PURCHASE DOCUMENT	ACCOUNT NO.
	400BT11
COMPLETE PARTIAL	FUND NO.
✓	3198
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
PP	1-25-01
INVOICE APPROVED	DATE

42000

I certify this to be an original invoice. Original was lost in the mail. Pam Perry

IMPORTANT INSTRUCTIONS

1. Make check payable to: **HCFA Laboratory Program**
2. Show CLIA Identification Number from this coupon on your check. Send Total Amount Due, **DO NOT SEND PARTIAL PAYMENT.**
3. Indicate any changes in name or address.
4. Include this coupon with your check.
5. For payment purposes our EIN number is 52 0883104

FORWARD REMITTANCE TO THE FOLLOWING ADDRESS:

HCFA LABORATORY PROGRAM
P.O. BOX 105422
ATLANTA, GA 30348-5422

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: TN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	120596

FOR AGENCY USE
WARRANT # 7640349 DATE: 01/17/2001

CLAIM OF:
METROCALL
541215634

1205961

FOR
$ 38.05

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932350000	3.95
000135	41000	3113	932350000	14.35
000135	42000	3113	932350000	19.75

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	38.05
026		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001228

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/25/2000	50502255428	38.05

THIS SPACE FOR AGENCY USE

400AT11 000135TN0A 311310637X		3.95
400B811 000135NE0A 311310637X		14.35
400BT11 000135NW97 311310637X		7.90
400BX11 000135NH0A 311310637X		3.95
400CX11 000135NN0A 311310637X		7.90

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 01/12/2001

Title Date

Agency, Bd or Div. Use

120596 Allen

METROCALL
STATE-DOH\CHILD ABUSE
ACCOUNT NUMBER 505-022554-28

PURCHASE ORDER NUMBER	X002279
INVOICE DATE	11/25/00
INVOICE NUMBER	2792302

FUND\ACCOUNT\SUBACT	OEC	AMOUNT	LIQ NUM.
191KDX1_010135NE0A_41000	3113 10637Y	35.55	24
266KDX1_000135NL0A_43000	3113 10637Y	23.70	25
400AT11_000135TN0A_42000	3113 10637Y	3.95	26
400B811_000135NE0A_41000	3113 10637Y	14.35	26
400BT11_000135NW97_42000	3113 10637Y	7.90	26
400BX111_000135NH0A_42000	3113 10637Y	3.95	26
400CX11_000135NN0A_42000	3113 10637Y	7.90	26
	TOTAL	97.30	

funded by GA
date 12/5/00

PURCHASE ORDER NUMBER	X002235
INVOICE DATE	11/25/00
INVOICE NUMBER	2792302

191KDX1_010135NG0A_42000	3113 10637Y	6.45	015
	TOTAL	6.45	
INVOICE TOTAL		**103.75**	

funded by GA
date 12/19/00

120594
120595
120596
120597

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-0225542B
Invoice Number: 2792302
Invoice Date: 11/25/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

RECEIVED
DEC 15 2000
Personnel Health Finance

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
158.59	75.05	1.89CR	79.65	103.75	183.40

Payments received after 11/25/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance		$	158.59
Payments Received Through 11/25/00		$	75.05
Adjustments to Previous Balance		$	1.89CR
Total Balance Forward	**Pay This Amount Now**		$ 79.65
Current Charges			
Service Charges		$	103.75
Usage Charges			
Equipment & Accessories			
Loss Protection			
Account Adjustments			
Connect Fee			
Late Fee			
Taxes & Other Charges			
Total Current Charges	**Pay Total Amount by 12/19/00 to Avoid Late Fee**		$ 103.75

XA02279
PURCHASE DOCUMENT | ACCOUNT NO.
COMPLETE | PARTIAL | FUND NO.
MATH CHECKED | OBJECT CODE
CLAIM ENTERED | CLAIM NUMBER
INVOICE APPROVED | DATE 12-19-00

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
103.75	79.65	0.00	0.00	183.40

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	2792302	11/25/00	103.75	183.40	

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AT 02 019104 08810B117 A**3DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000018340000010375279230228001200 3

DEC 15 2000

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 2792302
Invoice Date: 11/25/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
156.59	75.05	1.89CR	79.65	103.75	183.40

Payments received after 11/25/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Pager Number	Service Description	Service Dates	Amount
	Previous Balance		$ 156.59
	Payments Received		$ 75.05
	Numeric Svc Credit		$ 1.89CR
Total Balance Forward			**$ 79.65**

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
Higgins, K. (405) 559-0435	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 C1
Fletcher, A. (405) 559-5917	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 C1PPP
Gehue, C. (405) 620-9425	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 [illegible]
Robertson, L. (405) 620-9604	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 [illegible]
Talley, J. (405) 620-9973	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 OCRP
Rollins, J. (405) 630-3444	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 OLPP
Lorentz, D. (405) 636-5771	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 [illegible]
Clark, G. (405) 636-8629	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95 OCRP

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 2792302
Invoice Date: 11/25/00
P. O. Number: ~~X026721~~ X002279

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
156.59	75.05	1.89CR	79.65	103.75	183.40

Payments received after 11/25/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount	
Carter, S. (405) 647-2312	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	OCAP
Jacobi, A. (405) 660-6396	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	CF
Marr, P. (405) 660-7923	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	OCAP
Dooley, S. (405) 660-8524	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	[illegible]
Logan, S. (405) 690-0290	DD	11/09/00 Thru 11/28/00	$ 2.50	CG
	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	
Ramsey, M. (405) 690-1115	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	CF
ALES RET (405) 690-1117	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	CF
Cadaret, K. (405) 690-3767	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	CLAP
Fudge, D. (405) 690-4708	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	OCAP
Bonner, J. (405) 770-0873	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	CF
Middleton, K. (405) 770-1192	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	SEDI
Thoreson, L. (405) 770-3304	DD	10/28/00 Thru 11/28/00 OK	$ 3.95	CBFAS
	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	
Douglas, M. (405) 770-6946	DD	11/29/00 Thru 12/28/00	$ 3.95	OCAP

X 00235

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 4
Account Number: 505-022554-28
Invoice Number: 2792302
Invoice Date: 11/25/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
156.59	75.05	1.89CR	79.65	103.75	183.40

Payments received after 11/25/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount	
Coakley, K. (405) 800-6917	DD	11/09/00 Thru 11/28/00	$ 2.50	CBERS
	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	
Thoreson, L. (405) 800-8277	Extra Access Number with Extended Coverage		$ 0.00	
Horton, N. (918) 220-6504	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	OBL
Waldrop, S. (918) 220-6511	DD with Extended Coverage	11/29/00 Thru 12/28/00	$ 3.95	OBL
Total Current Activity			**$ 103.75**	

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: TN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	126587

FOR AGENCY USE
WARRANT # 7833505 DATE: 03/14/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932350000	23.70
000135	41000	3113	932350000	3.95

CLAIM OF:
METROCALL
541215634

1 2 6 5 8 7

FOR
$ 27.65

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	27.65
034		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010328

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/24/2001	50502255428	27.65

THIS SPACE FOR AGENCY USE

400AT11 000135TN0A 311310637X		3.95
400BT11 000135NW97 311310637X		7.90
400BX11 000135NH0A 311310637X		3.95
400CX11 000135NN0A 311310637X		7.90
400B811 000135NE0A 311310637X		3.95

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

ttach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices contract estimates may be attached provided they are to the same vendor and against the me contract, purchase or authorization order.

ch invoice must show on its face, the signature of the person who received and checked : merchandise. Contractor estimates must be approved by the architect or engineer in arge of the project. Receiving reports may be submitted in lieu of signed invoices.

ndors should file three copies of each invoice with the Department, Institution, or ency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 03/09/2001

Title Date

Agency, Bd or Div. Use

126585 126586

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 4874137
Invoice Date: 02/24/01
P. O. Number: ~~X028721~~

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Credit Amount, Do Not Pay
90.85	183.70	0.00	92.85CR	90.85	2.00CR

Payments received after 02/24/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Incorrectly Paid on Ck# belongs to 505013938-28

SUMMARY OF ACCOUNT CHARGES

Previous Balance		
Payments Received Through 02/24/01	$ 90.85	
Adjustments to Previous Balance	$ 183.70	
Total Balance Forward		$ 92.85CR
Current Charges		
Service Charges	$ 90.85	
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		$ 90.85

X002279
PURCHASE DOCUMENT | ACCOUNT NO.
COMPLETE | PARTIAL | FUND NO.
MATH CHECKED | OBJECT CODE
CLAIM ENTERED | CLAIM NUMBER
PP 3-7-01
INVOICE APPROVED | DATE

126585
126586
126587
126588

Pam

0-30 days	31-60 days	61-90 days	91 plus days	Credit Amount
2.00CR	0.00	0.00	0.00	2.00CR

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Credit Amount, Do Not Pay	Amount Paid
505-022554-28	4874137	02/24/01	90.85	2.00CR	

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AT 02 017978 90891B107 A**3DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000000200000009085487413728010300B

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 4874137
Invoice Date: 02/24/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Credit Amount, Do Not Pay
90.85	183.70	0.00	92.85CR	90.85	2.00CR

Payments received after 02/24/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 90.85
Payments Received	$ 183.70
Total Balance Forward	$ 92.85CR

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-0435	DD with Extended Coverage	03/01/01 Thru 03/28/01	$ 3.95
(405) 559-5917	DD with Extended Coverage	03/01/01 Thru 03/28/01	$ 3.95
(405) 620-9425	DD with Extended Coverage	03/01/01 Thru 03/28/01	$ 3.95
(405) 620-9604	DD with Extended Coverage	03/01/01 Thru 03/28/01	$ 3.95
(405) 620-9973	DD	02/08/01 Thru 02/28/01	$ 2.63CR
(405) 630-3444	DD with Extended Coverage	03/01/01 Thru 03/28/01	$ 3.95
(405) 630-3743	DD DD with Extended Coverage	02/08/01 Thru 02/28/01 03/01/01 Thru 03/28/01	$ 2.63 $ 3.95
(405) 636-5771	DD with Extended Coverage	03/01/01 Thru 03/28/01	$ 3.95
(405) 636-8629	DD with Extended Coverage	03/01/01 Thru 03/28/01	$ 3.95

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 4874137
Invoice Date: 02/24/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Credit Amount, Do Not Pay
90.85	183.70	0.00	92.85CR	90.85	2.00CR

Payments received after 02/24/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 647-2312	DD with Extended Coverage	03/01/01 Thru 03/28/01 191	$ 3.95
(405) 660-6396	DD with Extended Coverage	03/01/01 Thru 03/28/01 266	$ 3.95
(405) 660-7923	DD with Extended Coverage	03/01/01 Thru 03/28/01 191	$ 3.95
(405) 660-8524	DD with Extended Coverage	03/01/01 Thru 03/28/01 266	$ 3.95
(405) 690-0290	DD with Extended Coverage	03/01/01 Thru 03/28/01 191	$ 3.95
(405) 690-1115	DD with Extended Coverage	03/01/01 Thru 03/28/01 266	$ 3.95
(405) 690-3767	DD with Extended Coverage	03/01/01 Thru 03/28/01 [illegible]	$ 3.95
(405) 690-4708	DD with Extended Coverage	03/01/01 Thru 03/28/01 191	$ 3.95
(405) 770-0873	DD with Extended Coverage	03/01/01 Thru 03/28/01 266	$ 3.95
(405) 770-1192	DD with Extended Coverage	03/01/01 Thru 03/28/01 [illegible]	$ 3.95
(405) 770-3304	DD with Extended Coverage	03/01/01 Thru 03/28/01 [illegible]	$ 3.95
(405) 770-6946	DD	03/01/01 Thru 03/28/01 [illegible]	$ 3.95
(405) 800-6917	DD with Extended Coverage	03/01/01 Thru 03/28/01 [illegible]	$ 3.95 X0 [illegible]
(405) 800-8277	Extra Access Number with Extended Coverage		$ 0.00

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 4
Account Number: 505-022554-28
Invoice Number: 4874137
Invoice Date: 02/24/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Credit Amount, Do Not Pay
96.85	183.70	0.00	92.85CR	90.85	2.00CR

Payments received after 02/24/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(918) 220-6504	DD With Extended Coverage	03/01/01 Thru 03/28/01 400BT	$ 3.95
(918) 220-6511	DD With Extended Coverage	03/01/01 Thru 03/28/01 400BT	$ 3.95
Total Current Activity			$ 90.85

x

METROCALL

ACCT NO 50502255428

INV DATE 2/24/01 PER 03

VENDOR # 541215634

OBJECT CODE 311310637Y

BR Hartzell

PO X002279

191KDX1	010135NE0A	41000	32.92	32	126885
266KDX1	010135NL0A	43000	19.75	33	126586
400AT11	000135TN0A	41000	3.95		
400BT11	000135NW97	42000	7.9		
400BX11	000135NH0A	42000	3.95	34	126587
400CX11	000135NN0A	42000	7.9		
400B811	000135NE0A	41000	3.95		
			27.65		
			80.32		

PO X028721

400B811	000135NE0A	41000	3.95	23	126588
400CX11	000135NN0A	42000	6.58		
			10.53		
			90.85		

OSF FORM 15A
Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: TN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	130056

FOR AGENCY USE
WARRANT # 7937556 DATE: 04/13/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932350000	15.80
000135	41000	3113	932350000	7.90
000135	42000	3113	932350000	11.85

CLAIM OF:
METROCALL
541215634

1 3 0 0 5 6

FOR
$ 35.55

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	35.55
037		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010428

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/24/2001	50502255428	35.55

THIS SPACE FOR AGENCY USE

400AT11	000135TN0A	311310637X	3.95
400BT11	000135NW97	311310637X	7.90
400BX11	000135NH0A	311310637X	3.95
400B811	000135NE0A	311310637X	7.90
400CX11	000135NN0A	311310637X	11.85

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 04/11/2001

Title Date

Agency, Bd or Div. Use

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 5549334
Invoice Date: 03/24/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
[illegible]	[illegible]	0.00	[illegible]	176.86	[illegible]

Payments received after 03/24/01 will be reflected on your next invoice.

Any amount [illegible] will appear on [illegible]

Split Claim # 130056

SUMMARY OF ACCOUNT CHARGES

Previous Balance		$ 2.00CR
Payments Received Through 03/24/01		90.85
Adjustments to Previous Balance		
Total Balance Forward		$ 92.85CR
Current Charges		
Service Charges		84.01
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		92.85
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		**$ 176.86**

34-015-034

PURCHASE DOCUMENT [illegible] ACCOUNT NO.
COMPLETE PARTIAL FUND NO.
SUB ACTIVITY OBJECT CODE
MATH ENTERED CLAIM NUMBER
Pd 04-11-2001
INVOICE APPROVED DATE

Pay Total Amount Due by 04/17/01 to Avoid Late Fee

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
84.01	0.00	0.00	0.00	84.01

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	5549334	03/24/01	176.86	84.01	

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AT 02 018026 329758101 A**3DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000008401000017686554933428010400 2

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 5549334
Invoice Date: 03/24/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
2.00CR	90.85	0.00	92.85CR	178.05	84.01

Payments received after 03/24/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 2.00CR
Payments Received	$ 90.85
Total Balance Forward	**$ 92.85CR**

Current Activity

Pager Number	Service Description	Service Dates	Amount
	TRFR TO 505-13938		$ 84.86
	TRFR TO 505-013938		$ 7.99
(405) 505-0234	DD		$ 0.00
(405) 559-0435	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 559-5917	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 620-9425	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 620-9604	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 630-3444	DD	03/06/01 Thru 03/28/01	$ 2.89CR
(405) 630-3743	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 636-5771	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 636-8629	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 5549334
Invoice Date: 03/24/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
2.00CR	90.85	0.00	92.85CR	176.86	84.01

Payments received after 03/24/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 647-2312	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 660-6396	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 660-7923	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 660-8524	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 690-0290	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 690-1115	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 690-3767	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 690-4708	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 770-0873	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 770-1192	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 770-3304	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 770-6946	DD	03/29/01 Thru 04/28/01	$ 3.95
(405) 800-6917	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 3.95
(405) 800-8277	Extra Access Number with Extended Coverage		$ 0.00

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 4
Account Number: 505-022654-28
Invoice Number: 5549334
Invoice Date: 03/24/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
[illegible]	[illegible] 85.85	0.00	92.85CR	176.81	[illegible]

Payments received after 03/24/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(918) 220-6504	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 9.95
(918) 220-6511	DD with Extended Coverage	03/29/01 Thru 04/28/01	$ 9.95
Total Current Activity			**$ 176.86**

METROCALL

ACCT NO 50502255428

INV DATE 3/24/01

VENDOR # 541215634

OBJECT CODE 311310637X

PO X002279

191KDX1	010135NE0A	41000	28.71	
266KDX1	000135NL0A	43000	19.75	
400AT11	000135TN0A	42000	3.95	
400BT11	000135NW97	42000	7.9	
400BX11	000135NH0A	42000	3.95	35.55
400B811	000135NE0A	41000	7.9	
400CX11	000135NN0A	42000	11.85	
			84.01	

Ck# 130056

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: TN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X902279	202806

FOR AGENCY USE

WARRANT # 7069175 DATE: 07/25/2001

CLAIM OF:
METROCALL
541215634

ACCOUNT	SUBACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932830000	3.95
000135	41000	3113	931100000	13.69
000135	42000	3113	931970000	7.90
000135	42000	3113	932000000	3.95
000135	42000	3113	932350000	11.85

FOR
$ 41.34

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

Enter the partial payment or final partial number if claim is to be charged against an encumbered order

Partial No. 044 | Final No. | TOTAL AMOUNT $ 41.34

OSF AUDITED BY

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date

Claimant

WARRANT (LOCATOR) NO.

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY)

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/26/2001	50502255428	41.34

THIS SPACE FOR AGENCY USE

400AT11	000135TN0A	311310637X	3.95
400B811	000135NE0A	311310637X	13.69
400BT11	000135NW97	311310637X	7.90
400BX11	000135NH0A	311310637X	3.95
400CX11	000135NN0A	311310637X	11.85

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CTR
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorized order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 07/23/2001

Title Date

Agency, Bd or Div. Use

202806 fe

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

RECEIVED

For Questions Call
1 405 440-1400

Page: 1
Account Number: 505-022554-28
Invoice Number: 6877051
Invoice Date: 05/26/01
P. O. Number: X028721 & X002279

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
61.62	67.15	0.00	5.53CR	76.63	71.10

Payments received after 05/26/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit

SUMMARY OF ACCOUNT CHARGES

Previous Balance	$ 61.62	
Payments Received Through **05/26/01**	$ 67.15	
Adjustments to Previous Balance		
Total Balance Forward		$ 5.53CR
Current Charges		
Service Charges	$ 76.63	
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		$ 76.63

Con# 202805
202806

Pay Total Amount Due by 06/19/01 to Avoid Late Fee

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
71.10	0.00	0.00	0.00	71.10

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	6877051	05/26/01	76.63	71.10	

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AT 01 014039 360928 85 A**3DGT
STATE-DOH/CHILD ABUSE
ATTACCOUNTS PAYABLE
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000007110000007663687705128010600 5

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 6877051
Invoice Date: 05/26/01
P. O. Number: X028721 & X002279

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
61.62	67.15	0.00	5.53CR	76.63	71.10

Payments received after 05/26/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 61.62
Payments Received	$ 67.15
Total Balance Forward	**$ 5.53CR**

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-4712	DD	05/16/01 Thru 05/28/01	$ 1.58
	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 559-5917	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 620-9425	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 620-9604	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 630-3444	DD	05/14/01 Thru 05/28/01	$ 1.84
	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 630-3743	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 636-5771	DD with Extended Coverage	05/29/01 Thru 06/28/01	$ 3.95
(405) 636-8629	DD with Extended Coverage	05/29/01 Thru 06/28/01	$ 3.95
(405) 647-2312	DD with Extended Coverage	05/29/01 Thru 06/28/01	$ 3.95
(405) 660-7923	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 660-8524	DD	05/14/01 Thru 05/28/01	$ 1.84CR

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 6877051
Invoice Date: 05/26/01
P. O. Number: X028721 & X002279

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
61.62	67.15	0.00	5.53CR	76.63	71.10

Payments received after 05/26/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 690-0280	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 690-3767	DD with Extended Coverage	05/29/01 Thru 06/28/01	$ 3.95
(405) 690-4708	DD with Extended Coverage	05/29/01 Thru 06/28/01	$ 3.95
(405) 770-1192	DD with Extended Coverage	05/29/01 Thru 06/28/01	$ 3.95
(405) 770-3304	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 770-6946	DD	05/29/01 Thru 06/28/01	$ 3.95
(405) 800-6917	DD with Extended Coverage	05/29/01 Thru 06/28/01	$ 3.95
(405) 800-8277	Extra Access Number		$ 0.00
(918) 220-6504	DD	05/29/01 Thru 06/28/01	$ 3.95
(918) 220-6511	DD	05/29/01 Thru 06/28/01	$ 3.95
Total Current Activity			**$ 76.63**

JUN 0 5 2001

PAGER/PHONES Query

6/4/01

U# 541215634 LIQ 041 [illegible] 687705

50502255428	GEHUE	C	405-620-9425	191KDX1	010135NE0A	41000	X002279	$3.95	
50502255428	DOUGLASS	M	405-770-6946	191KDX1	010135NE0A	41000	X002279	$3.95	
50502255428	CLARK	GINGER	405-636-8629	191KDX1	010135NE0A	41000	X002279	$3.95	
50502255428	TALLEY	JAMES	405-559-4712	191KDX1	010135NE0A	41000	X002279	$3.95	+1.55 3318
50502255428	CARTER	S	405-647-2312	191KDX1	010135NE0A	41000	X002279	$3.95	~~25.20~~
50502255428	FUDGE	D	405-690-4708	191KDX1	010135NE0A	41000	X002279	$3.95	
50502255428		LORI	405-690-0290	191KDX1	010135NG0A	42000	X002235	$3.95	
50502255428	MARR	P	405-660-7923	191KDX1	010135NE0A	41000	X002279	$3.95	3.95
50502255428	ROBERTSON	L	405-620-9604	191KDX1	010135NE0A	41000	X002279	$3.95	
50502255428	LORENZ	D	405-636-5771	400AT11	000135TN0A	42000	X002279	$3.95	
50502255428	COAKLEY	KAREN	405-800-6917	400B811	000135NE0A	41000	X002279	$3.95	
50502255428	THORESON	L	405-770-3304	400B811	000135NE0A	41000	X002279	$3.95	
50502255428	SHOEMAKER	JENNIFER	405-630-3444	400B811	000135NE0A	41000	X002279	$3.95	+1.84
50502255428	WALDRON	S	918-220-6511	400BT01	000135NW97	42000	X002279	$3.95	
50502255428	HORTON	N	918-220-6504	400BT01	000135NW97	42000	X002279	$3.95	
50502255428	MIDDLETON	KATHY	405-770-1192	400BX11	000135NH0A	42000	X002279	$3.95	
50502255428	FLETCHER	A	405-559-5917	400CX11	000135NN0A	42000	X002279	$3.95	
50502255428	HILL	PAT	405-630-3743	400CX11	000135NN0A	42000	X002279	$3.95	
50502255428	CADARET	K	405-690-3767	400CX11	000135NN0A	42000	X002279	$3.95	

X002279

AMO

191KDX1 010135NE0A 41000 3318 041 $37.13 cl# 202805 ~~136118~~

191KDX1 ~~010135NE0A~~ 41000 395

400AT11 000135TN0A 42000 395 042 cl#

400B811 000135NE0A 41000 1369

400BT11 000135NW97 42000 740 202806

400BX11 000135NH0A 42000 395

400CX11 000135NN0A 42000 11.55 841.34

7547

** AGENCY COPY ** SVC CHF: TN

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	117101

FOR AGENCY USE: WARRANT # 7541185 DATE: 12/11/2000

ACCOUNT	SUBACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932350000	3.95

Enter the partial payment or final payment number if claim is to be charged against an encumbered order

Partial No.	Final No.	TOTAL AMOUNT $	24.09
023		OSF AUDITED BY	

CLAIM OF:
METROCALL
541215634

1 1 7 1 0 1

FOR
$ 24.09

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

WARRANT (LOCATOR) NO.

I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee

Date

Claimant

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY) 20001128

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/28/2000	2081707	24.09

THIS SPACE FOR AGENCY USE

400AT11	000135TN0A	311310637Y	4.08
400BT11	000135NW97	311310637Y	7.90
400BX11	000135NH0A	311310637Y	3.95
400CX11	000135NN0A	311310637Y	8.16

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attached invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contract estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 12/07/2000

Title Date

Agency, Bd or Div. Use

117101 MT

METROCALL
STATE-DOH\CHILD ABUSE
ACCOUNT NUMBER 505-022554-28

PURCHASE ORDER NUMBER	X002279
INVOICE DATE	10/28/00
INVOICE NUMBER	2081707

FUND\ACCOUNT\SUBACT	OEC	AMOUNT	LIQ NUM.
191KDX1_010135NE0A_41000	3113 10637Y	35.68	21
266KDX1_000135NL0A_43000	3113 10637Y	19.88	22
400AT11_000135TN0A_42000	3113 10637Y	4.08	23
400B811_000135NE0A_41000	3113 10637Y	0.00	23
400BT11_000135NW97_42000	3113 10637Y	7.90	23
400BX111_000135NH0A_42000	3113 10637Y	3.95	23
400CX11_000135NN0A_42000	3113 10637Y	8.16	23
	TOTAL	79.65	

funded by Sonja Joyce Fouquet
date 12/5/00

Pd # 117102
117103

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 2081707
Invoice Date: 10/28/00
P. O. Number: ~~X028721~~

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
209.13	132.19	0.00	76.94	79.65	156.59

Payments received after 10/28/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance	$	209.13
Payments Received Through **10/28/00**	$	132.19
Adjustments to Previous Balance		
Total Balance Forward		$ 76.94

X003279

Pay This Amount Now $ 79.65

[redacted]
PURCHASE DOCUMENT | ACCOUNT NO. $
COMPLETE | PARTIAL | FUND NO.
MATH CHECKED | OBJECT CODE
CLAIM ENTERED | CLAIM NUMBER
[illegible] | 11-22-00
INVOICE APPROVED | DATE

RECEIVED
NOV 21 2000
Personal Health Finance

Current Charges
Service Charges
Usage Charges
Equipment & Accessories
Loss Protection
Account Adjustments
Connect Fee
Late Fee
Taxes & Other Charges

Total Current Charges **Pay Total Amount by 11/21/00 to Avoid Late Fee** $ 79.65

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
79.65	65.44	11.50	0.00	156.59

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	2081707	10/28/00	79.65	156.59	79.65

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AT 02 019977 67954B114 A**3DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000015659000007965208170728001l008

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 2081707
Invoice Date: 10/28/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
209.13	132.19	0.00	76.94	79.65	156.59

Payments received after 10/28/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 209.13
Payments Received	$ 132.19
Total Balance Forward	**$ 76.94**

Current Activity

Pager Number	Service Description	Service Dates	Amount	
Not Found				
(405) 505-0234	DD		$ 0.00	
Higgins, K.				
(405) 559-0435	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	NL
Fletcher, A.				
(405) 559-5917	DD	10/27/00 Thru 10/28/00	$ .13	
	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	NN
Gehue, C.				
(405) 620-9425	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	NE-191
Roberson, L.				
(405) 620-9604	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	NE-191
Jailer, S.				
(405) 620-9973	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	NE-191
Rolling T.				
(405) 630-3444	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	NE-191
Lorenz, D.				
(405) 636-5771	DD	10/27/00 Thru 10/28/00	$ .13	
	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	HOORTH
Clark, ...				
(405) 636-8629	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95	NE 191

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 2081707
Invoice Date: 10/28/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
209.13	132.19	0.00	76.94	79.65	156.59

Payments received after 10/28/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
Carter, S. (405) 647-2312	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 NE 191
Jacobi, A. (405) 660-6396	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 266
Marr, P. (405) 660-7923	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 NE 191
Pooley, S. (405) 660-8524	DD DD with Extended Coverage	10/27/00 Thru 10/28/00 10/29/00 Thru 11/28/00	$ .13 $ 3.95 266
Ramsey, M. (405) 690-1115	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 266
Iles, B. (405) 690-1117	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 266
Cadaret, K. (405) 690-3767	DD DD with Extended Coverage	10/27/00 Thru 10/28/00 10/29/00 Thru 11/28/00	$ .13 $ 3.95 NN
Pudge, O. (405) 690-4708	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 NE 191
Lewis, J. (405) 770-0873	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 266
Middleton, K (405) 770-1192	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 NH
Not Found (405) 770-4678	DD Sally Gunn	09/29/00 Thru 10/28/00	$ 3.95CR (266)
Douglas, M. (405) 770-6946	DD DD	10/27/00 Thru 10/28/00 10/29/00 Thru 11/28/00	$ .13 $ 3.95 NE 191
Horton, N. (918) 220-6504	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95 NW 91

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 4
Account Number: 505-022554-28
Invoice Number: 2081707
Invoice Date: 10/28/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
209.13	132.19	0.00	76.94	79.65	156.59

Payments received after 10/28/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
Waldron, S. (918) 220-6511	DD with Extended Coverage	10/29/00 Thru 11/28/00	$ 3.95
Total Current Activity			**$ 79.65**

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: TN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	120600

FOR AGENCY USE
WARRANT # 7640353 DATE: 01/17/2001

CLAIM OF:
METROCALL
541215634

1 2 0 6 0 0

FOR
$ 31.60

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932350000	23.70
000135	41000	3113	932350000	7.90

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
029		31.60

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010128

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/23/2000	50502255428	31.60

THIS SPACE FOR AGENCY USE

400AT11	000135TN0A	311310637Y	3.95
400BT11	000135NW97	311310637Y	7.90
400BX11	000135NH0A	311310637Y	3.95
400CX11	000135NN0A	311310637Y	7.90
400B811	000135NE0A	311310637Y	7.90

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise.Contractor estimates must be approved by the architect or engineer in charge of the project.Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 01/12/2001

Title Date

Agency, Bd or Div. Use

120600

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 3494339
Invoice Date: 12/23/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
183.40	79.65	0.00	103.75	87.82	191.57

Payments received after 12/23/00 will be reflected on your next invoice. pc missing

Any amount followed by a "CR" is a credit.

SUMMARY OF ACCOUNT CHARGES

Previous Balance $ 183.40
Payments Received Through 12/23/00 $ 79.65
Adjustments to Previous Balance
Total Balance Forward **Pay This Amount Now** $ 103.75

Current Charges
Service Charges $ 87.82
Usage Charges
Equipment & Accessories
Loss Protection
Account Adjustments
Connect Fee
Late Fee
Taxes & Other Charges

120598
120599
120600
120601

Total Current Charges **Pay Total Amount by 01/16/01 to Avoid Late Fee** $ 87.82

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
87.82	103.75	0.00	0.00	191.57

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	3494339	12/23/00	87.82	191.57	

If You Have Questions, Call Customer Care **1 405 440-1400** ☐ Check here for change of address (see reverse)

AT 02 019820 42503B117 A**3DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000019157000008782349433928010100 6

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 605-022554-28
Invoice Number: 3494339
Invoice Date: 12/23/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
183.40	79.65	0.00	103.75	87.82	191.57

Payments received after 12/23/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 183.40
Payments Received	$ 79.65
Total Balance Forward	**$ 103.75**

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-0435	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 559-5917	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 620-9425	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 620-9604	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 620-9973	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 630-3444	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 636-5771	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 636-8629	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 647-2312	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 3494339
Invoice Date: 12/23/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
183.40	79.65	0.00	103.75	87.82	191.57

Payments received after 12/23/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 660-6396	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 660-7923	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 660-8524	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 690-0290	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 690-1115	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 690-3767	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 690-4708	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 770-0873	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 770-1192	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 770-3304	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 770-6946	DD	12/29/00 Thru 01/28/01	$ 3.95
(405) 800-6917	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(405) 800-8277	Extra Access Number with Extended Coverage		$ 0.00
(918) 220-6504	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 4
Account Number: 505-022554-28
Invoice Number: 3494339
Invoice Date: 12/23/00
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
183.40	79.65	0.00	103.75	87.82	191.57

Payments received after 12/23/00 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(918) 220-6511	DD with Extended Coverage	12/29/00 Thru 01/28/01	$ 3.95
(918) 646-7335	DD	12/05/00 Thru 12/28/00	$ 3.03CR
Total Current Activity			**$ 87.82**

METROCALL

ACCT NO 50502255428

INV DATE 12/23/00

VENDOR # 541215634

OBJECT CODE 311310637Y

PO X002279

191KDX1	010135NE0A	41000	32.52	029
266KDX1	000135NL0A	43000	19.75	028
400AT11	000135TN0A	41000	3.95	
400BT11	000135NW97	42000	7.9	
400BX11	000135NH0A	42000	3.95	028
400CX11	000135NN0A	42000	7.9	
400B811	000135NE0A	41000	~~3.95~~ 7.90	
			27.65	

PO X028721

191G511	190135TN97	30002	3.95	016
~~400B811~~	~~000135NE0A~~	~~41000~~	~~3.95~~	~~015~~

87.82

BL Hartzell

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: TN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	124062

FOR AGENCY USE
WARRANT # 7747198 DATE: 02/16/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	932350000	23.70
000135	41000	3113	932350000	3.95

CLAIM OF:
METROCALL
541215634

1
2
4
0
6
2

FOR
$ 27.65

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	27.65
032		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY) 20010228

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
01/27/2001	4189774	27.65

THIS SPACE FOR AGENCY USE

400AT11	000135TN0A	311310637Y	3.95
400BT11	000135NW97	311310637Y	7.90
400BX11	000135NH0A	311310637Y	3.95
400CX11	000135NN0A	311310637Y	7.90
400B811	000135NE0A	311310637Y	3.95

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 02/13/2001

Title Date

Agency, Bd or Div. Use

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 4189774
Invoice Date: 01/27/01
P. O. Number: [redacted]

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
191.57	191.57	0.00	0.00	90.85	90.85

Payments received after 01/27/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit

SUMMARY OF ACCOUNT CHARGES

Previous Balance		
Payments Received Through 01/27/01	$ 191.57	
Adjustments to Previous Balance		
Total Balance Forward		$ 0.00
Current Charges		
Service Charges	$ 90.85	
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		$ 90.85

5412156234
X002279
PURCHASE DOCUMENT | ACCOUNT NO.
COMPLETE | PARTIAL | FUND NO
MATH CHECKED | OBJECT CODE
ENTERED | CLAIM NUMBER
PP 2-2-01
see attached

Pay Total Amount by 02/20/01 to Avoid Late Fee

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
90.85	0.00	0.00	0.00	90.85

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	4189774	01/27/01	90.85	90.85	

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AT 02 019043 87838B108 A**3DGT
STATE-DOH/CHILD ABUSE
ATT PAM PERRY
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000009085000009085418977428010200?

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 4189774
Invoice Date: 01/27/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
191.57	191.57	0.00	0.00	90.85	90.85

Payments received after 01/27/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 191.57
Payments Received	$ 191.57
Total Balance Forward	$ 0.00

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-0435	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 559-5917	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 620-9425	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 620-9604	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 620-9973	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 630-3444	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 636-5771	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 636-8629	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 647-2312	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 4189774
Invoice Date: 01/27/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
191.57	191.57	0.00	0.00	90.85	90.85

Payments received after 01/27/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(405) 660-6396	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 660-7923	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 660-8524	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 690-0290	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 690-1115	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 690-3767	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 690-4708	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 770-0873	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 770-1192	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 770-3304	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 770-6946	DD	01/29/01 Thru 02/28/01	$ 3.95
(405) 800-6917	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
(405) 800-8277	Extra Access Number with Extended Coverage		$ 0.00
(918) 220-6504	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95

*** Continued on next page ***

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 4
Account Number: 505-022554-28
Invoice Number: 4189774
Invoice Date: 01/27/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
101.57	101.57	0.00	0.00	90.85	90.85

Payments received after 01/27/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount
(918) 220-6511	DD with Extended Coverage	01/29/01 Thru 02/28/01	$ 3.95
Total Current Activity			**$ 90.85**

x

METROCALL period 2

ACCT NO 50502255428

INV DATE 1/27/01

VENDOR # 541215634

OBJECT CODE 311310637Y

PO X002279

191KDX1	010135NE0A	41000	3.95	30	D14603
266KDX1	000135NL0A	43000	15.8	31	D14604
400AT11	000135TN0A	41000	3.95		
400BT11	000135NW97	42000	7.9		
400BX11	000135NN0A	42000	3.95	32	D14607
400CX11	000135NN0A	42000	7.9		
400B811	000135NE0A	41000	3.95		
			27.65		

PO X028721

~~191G511~~	~~000135TN97~~	~~38002~~	~~3.95~~	~~17~~	
400B811	000135NE0A	41000	3.95	18	D14611

PO X002235

191KDX1	010135NG0A	42000	3.95	17	D14606
			90.85		

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X002279	133860

FOR AGENCY USE
WARRANT # 8052950 DATE: 05/17/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3113	000000000	11.85
000135	42000	3113	932000000	3.95
000135	42000	3113	931970000	7.90
000135	42000	3113	931100000	3.95
000135	41000	3113	932350000	7.90

CLAIM OF:
METROCALL
541215634

1 3 3 8 6 0

FOR
$ 35.55

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	35.55
040		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010428

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
04/28/2001	6217697	35.55

THIS SPACE FOR AGENCY USE

400CX11	000135NN0A	311310637Y	11.85
400BX11	000135NH0A	311310637Y	3.95
400BT11	000135NW97	311310637Y	7.90
400AT11	000135TN0A	311310637Y	3.95
400B811	000135NE0A	311310637Y	7.90

J/E XREF:

VENDOR: METROCALL
ADDRESS: PAYMENT PROCESSING CENTER
ADDRESS: PO BOX 78215
CITY/ST/ZIP: PHOENIX AZ 850628215

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 05/15/2001

Title Date

Agency, Bd or Div. Use

133840 pd

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 1
Account Number: 505-022554-28
Invoice Number: 6217697
Invoice Date: 04/28/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
84.01	84.01	0.00	0.00	61.62	61.62

Payments received after 04/28/01 will be reflected on your next invoice

Any amount followed by a "CR" is a credit

SUMMARY OF ACCOUNT CHARGES

Previous Balance	$ 84.01	
Payments Received Through 04/28/01	$ 84.01	
Adjustments to Previous Balance		
Total Balance Forward		$ 0.00
Current Charges:		
Service Charges	$ 61.62	
Usage Charges		
Equipment & Accessories		
Loss Protection		
Account Adjustments		
Connect Fee		
Late Fee		
Taxes & Other Charges		
Total Current Charges		$ 61.62

Pay Total Amount Due by 05/22/01 to Avoid Late Fee

0-30 days	31-60 days	61-90 days	91 plus days	Total Amount Due
61.62	0.00	0.00	0.00	61.62

FOR CUSTOMER USE
Amount Paid_____
Date Paid_____
Check #_____

Please tear here and return this portion with your payment

METROCALL
AMERICA'S WIRELESS NETWORK

Account Number	Invoice Number	Invoice Date	Current Charges	Total Amount Due	Amount Paid
505-022554-28	6217697	04/28/01	61.62	61.62	61.62

If You Have Questions, Call Customer Care **1 405 440-1400**

☐ Check here for change of address (see reverse)

AT 01 014925 83608B 83 A**3DGT
STATE-DOH/CHILD ABUSE
ATTACCOUNTS PAYABLE
1000 NE 10TH RM 506
OKLAHOMA CITY OK 73117-1207

Send Check Payable to:

Metrocall
Payment Processing Center
PO Box 78215
Phoenix AZ 85062-8215

505022554283000006162000006162621769728010500 7

133860 pay

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 2
Account Number: 505-022554-28
Invoice Number: 6217697
Invoice Date: 04/28/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
84.01	84.01	0.00	0.00	61.62	61.62

Payments received after 04/28/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

DETAILED ACCOUNT CHARGES

Previous Activity

Service Description	Amount
Previous Balance	$ 84.01
Payments Received	$ 84.01
Total Balance Forward	**$ 0.00**

Current Activity

Pager Number	Service Description	Service Dates	Amount
(405) 505-0234	DD		$ 0.00
(405) 559-0435	DD	04/10/01 Thru 04/28/01	$ 2.37CR
(405) 559-5917	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95 CX
(405) 620-9425	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95 NE 191
(405) 620-9604	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95 NE 191
(405) 630-3743	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95 NN CX
(405) 636-5771	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95 AT
(405) 636-8629	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95 NE 191
(405) 647-2312	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95 NE 191 EA
(405) 660-6396	DD	04/10/01 Thru 04/28/01	$ 2.37CR

* credits are for account 266. Only have one number for that Amount. ~~to~~ 660-8524. Credit Remaining is (5.53) Use on Next Invoice

*** Continued on next page ***

133860

METROCALL
AMERICA'S WIRELESS NETWORK

Metrocall
P.O. Box 78215
Phoenix, AZ 85062-8215

Page: 3
Account Number: 505-022554-28
Invoice Number: 6217697
Invoice Date: 04/28/01
P. O. Number: X028721

For Questions Call
1 405 440-1400

STATE-DOH/CHILD ABUSE

Previous Balance	Payments Received	Adjustments to Previous Balance	Balance Forward	Current Charges	Total Amount Due
84.01	84.01	0.00	0.00	61.62	61.62

Payments received after 04/28/01 will be reflected on your next invoice.

Any amount followed by a "CR" is a credit.

Current Activity (continued)

Pager Number	Service Description	Service Dates	Amount	
(405) 660-7923	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NE 191
(405) 660-8524	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NE 266
(405) 690-0290	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NE 191
(405) 690-1115	DD	04/10/01 Thru 04/28/01	$ 2.37CR	
(405) 690-3767	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NH CX
(405) 690-4708	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NE 191
(405) 770-0873	DD	04/10/01 Thru 04/28/01	$ 2.37CR	
(405) 770-1192	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NH BX
(405) 770-3304	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NE -BX
(405) 770-6946	DD	04/29/01 Thru 05/28/01	$ 3.95	NE 191
(405) 800-6917	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	NE BX
(405) 800-8277	Extra Access Number with Extended Coverage		$ 0.00	
(918) 220-6504	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	400BX
(918) 220-6511	DD with Extended Coverage	04/29/01 Thru 05/28/01	$ 3.95	400BX
Total Current Activity			$ ~~61.62~~ 67.15	

Didn't use 5.53 credit. Credit belongs to Fund 266, only here as Phoenix left an account. Use credit of ~~[illegible]~~ Following Invoices.

133860pd

METROCALL
541215634

400CX11	000135NN0A	42000	11.85	X002279	
400BX11	000135NH0A	42000	3.95	X002279	
400BT11	000135NW97	42000	7.90	X002279	
400AT11	000135TN0A	42000	3.95	X002279	5050225542 8
400B811	000135NE0A	42000	7.90	X002279	
			35.55		
191KDX1	010135NE0A	41000	27.65	X002279	Cl#133858
191KDX1	010135NG0A	41000	3.95	X002235	Cl#133857
			31.60		
TOTAL			67.15		

Cl #133857

PURCHASE DOCUMENT X002235 ACCOUNT NO. 010135NG0A
COMPLETE PARTIAL 041 FUND NO. 191KDX1
SUB ACTIVITY 41000 OBJECT CODE 3113106231V
MATH ✓ ENTERED CLAIM NUMBER
INVOICE APPROVED Pal DATE 05-15-2001

$3.95

Cl#133858

PURCHASE DOCUMENT X002279 ACCOUNT NO. 010135NE0A
COMPLETE PARTIAL 039 FUND NO. 191KDX1
SUB ACTIVITY 41000 OBJECT CODE 3113106231V
MATH ✓ ENTERED CLAIM NUMBER
INVOICE APPROVED Pal DATE 05-15-2001

$27.65

X002279 541215634

PURCHASE DOCUMENT ACCOUNT NO. SPLIT
COMPLETE PARTIAL FUND NO. SPLIT
SUB ACTIVITY SPLIT OBJECT CODE
MATH ✓ ENTERED CLAIM NUMBER
INVOICE APPROVED Pal DATE 05-14-00

X002279 → 191 → 27.65
X → 191 → $31.60 Ly 039

400 35.55 Ly 040

Cl#133860

PURCHASE DOCUMENT X002279 ACCOUNT NO. 010135SPLIT
COMPLETE PARTIAL 040 FUND NO. 400SPLIT
SUB ACTIVITY SPLIT OBJECT CODE 3113106231V
MATH ✓ ENTERED CLAIM NUMBER
INVOICE APPROVED Pal DATE 05-15-2001

OSF FORM 15A
(Revised.1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	114112

FOR AGENCY USE
WARRANT # 7448899 DATE: 11/13/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	000000000	174.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1 1 4 1 1 2

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	174.00
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001101

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/02/2000	402499	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

_____
Agency's Approving Officer

11/08/2000

Title Date

Agency, Bd or Div. Use

pH

11/12 MT

The RKBlack Connection

RK Black Inc. CopySolutions Marathon

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
402499	NET 10

SHIP VIA:

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 73117-12

ACCOUNT #	PURCHASE ORDER NO.	SALES PERSON	SHIPPED VIA	SHIPPING DATE	INVOICE DATE
2715868	T072445	OK HOUSE ACCOUN		10/02/00	10/02/00

ORD	SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC	NET PRICE	AMOUNT
				* MAINTENANCE CONTRACT NO. 18330					One month 174.00
4	4		EA	AFICIO COLOR 3006	RICOH EPG	174.00		174.00	~~696.00~~
				SERIAL NO. 0100100116					per contract
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
				DOES NOT INCLUDE SUPPLIES. RCV					
				THIS BILLING FOR MONTH PERIOD. FUTURE BILLINGS					
				WILL BILL MONTHLY... RCV					174.00
							SUBTOTAL		~~696.00~~

FINANCIAL MANAGEMENT
2000 OCT 12 P 3:42
RECEIVED

RECEIVED
OCT 13 2000
Personal Health Finance

	FREIGHT	.00
	SALES TAX	.00
Please show INVOICE and ACCOUNT # on remittance		~~696.00~~ 174.00

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

Financial Management Service

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated [illegible] 13977

Personal Health

Vendor Name: The R K Black Connection

Vendor Number:

Invoice Number: 402499

Invoice Date: 10/2/00

Amount: $696.00

Order Number: T072445

Audited By: Bonnie Hartzell

Date Rejected: 10/13/00

Funding

- ☐ Funding Not Indicated
- ☐ Does Not Match Encumbrance
- ☐ Invalid Fund
- ☐ Invalid Account
- ☐ Invalid Sub-Account
- ☐ Invalid Object

Signature

- ☐ Vendor Signature
- ☐ Supervisor Signature
- ☐ Funding Block

Verify The Following

- ☐ Verify Vendor [illegible]
- ☐ Verify Order [illegible]

Not Enough Allotment

- ☐ 1st Quarter Allotment Insufficient
- ☐ 2nd Quarter Allotment Insufficient
- ☐ 3rd Quarter Allotment Insufficient
- ☐ 4th Quarter Allotment Insufficient

Need Additional Information

- ☐ Certified Invoice Copy
- ☐ Proof of Delivery
- ☐ Notary Seal Missing
- ☐ Notary Signature Missing
- ☐ Notary County or State Incomplete
- ☐ Notary Expired [illegible]
- ☐ Changes Need Justification
- ☐ Changes Need Authorizing Initials
- ☐ Item Not Found

Mathematical Errors

- ☐ Calculations Inaccurate
- ☐ Cross Footing Inaccurate
- ☐ Price Discrepancy

Encumbrance Problems

- ☐ [illegible]
- ☐ [illegible]
- ☐ [illegible]

Required Data

- ☐ [illegible]
- ☐ [illegible]
- ☐ [illegible]

Other Remarks or Comments:

For your approval

16 A 10:41
MANAGEMENT

Division Finance Area Comments

funding on back

RECEIVED
OCT 13 2000
Personal Health Finance

Please Return This Document To Financial Management

Financial Management Service

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To: 14102

Personal Health

Vendor Name: R K BLACK

Vendor Number: 730674578

Invoice Number: 402499

Invoice Date: 10/2/00

Amount: $174.00

Order Number: T072445

Audited By: Dwight Burleson

Date: 10/24/00

Funding

- ☐ Funding Not Indicated
- ☐ Does Not Match Encumbrance
- ☑ Invalid Fund
- ☑ Invalid Account
- ☐ Invalid Sub-Activity
- ☐ Invalid Object Code

Signature

- ☐ [illegible]
- ☐ [illegible]
- ☐ [illegible]

Vendor Tax Information

- ☐ [illegible]
- ☐ [illegible]

Not Enough Allotment

- ☐ 1st Quarter Allotment Insufficient
- ☐ 2nd Quarter Allotment Insufficient
- ☐ 3rd Quarter Allotment Insufficient
- ☐ 4th Quarter Allotment Insufficient

Need Additional Information

- ☐ Certified Invoice
- ☐ Proof of Delivery
- ☐ Notary Seal Missing
- ☐ Notary Signature Missing
- ☐ Notary County or State Incomplete
- ☐ Notary Expired (Not Valid)
- ☐ Changes Need Justification
- ☐ Changes Need Authorizing Initials
- ☐ Item Not Found

Mathematical Errors

- ☐ Calculation
- ☐ Cross Foot
- ☐ Price Discrepancy

Encumbrance Problem

- ☐ Invoice
- ☐ Invoice
- ☐ Order

Required Date

- ☐ Invoice Date of Service
- ☐ Notary Date of Invoice
- ☐ Notary Date of Service

Other Remarks or Comments:

RECEIVED

OCT 25 2000

Personal Health Finance

Division Finance Area Comments

2000 NOV -6 P

FINANCIAL MA

Please Return This Document To Financial Management

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	117298

FOR AGENCY USE
WARRANT # 7552500 DATE: 12/14/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	939450000	174.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1 1 7 2 9 8

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRENT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
003		174.00

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001201

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/16/2000	404589	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

12/11/2000

Title Date

Agency, Bd or Div. Use

FH

The Black Connection

Mack Inc. CopySolutions Marathon

IETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984
(405) 943-9801

PROCUREMENT
OCT 2 4 2000
RECEIVED

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
404589	NET 10

SHIP VIA:

11798 pr

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 73117

CUSTOMER NO.	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
6858	T072445	OK HOUSE ACCOUN		10/16/00	10/16/00

P	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC	NET PRICE	AMOUNT
			* MAINTENANCE CONTRACT NO. 18330					
			BILLING PERIOD FROM 11/2/00 THROUGH 12/1/00					
1		EA	AFICIO COLOR 3006	RICOH EPG	174.00		174.00	174.0
			SERIAL NO. 01001100116					
			SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
			DOES NOT INCLUDE SUPPLIES. RCV					
						SUBTOTAL		174.0
						FREIGHT		.00
						SALES TAX		.00

RECEIVED
2000 OCT 24 P 4:06

FINANCIAL MANAGEMENT

NOV 2 7 2000

Personal Health Finance

PURCHASE DOCUMENT 10729[illegible] ACCOUNT NO. 0013540997
COMPLETE 003 ACCOUNT NO. 2003111
MATH CHECKED 72000 FUND NO. 33224-X
ORG. CODE
CLASS ENCUMBERED CLASS NUMBER
INVOICE 1306/60 DATE 11-27-00

1TH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
JECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

174.0[illegible]

Financial Management Service

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To: 14108

Personal Health

Vendor Number

The R K Black Connection

404589 | Invoice Date: 10/16/00 | Amount: $174.00

T072445 | Audited By: Bonnie Hartzell | Date: 10/25/00

Not Enough Allotment

- ☐ 1st Quarter Allotment Insufficient
- ☐ 2nd Quarter Allotment Insufficient
- ☐ 3rd Quarter Allotment Insufficient
- ☐ 4th Quarter Allotment Insufficient

Need Additional Information

- ☐ Certified Invoice
- ☐ Proof of Delivery
- ☐ Notary Seal
- ☐ Notary Signature
- ☐ Notary Commission Incomplete
- ☐ Notary Expired
- ☐ Changes Needed
- ☐ Changes Needed Initials
- ☐ Item Not Found

Other Remarks or Comments

For your approval

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DEC -6 P 4:10
FINANCIAL MANAGEMENT

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OCT 25 2000
Personal Health Finance

Division Finance Area Comments

NOV 27 2000

Personal Health Finance

Please Return This Document To Financial Management

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	122824

FOR AGENCY USE
WARRANT # 7708020 DATE: 02/06/2001

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	939440000	174.00

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
006		174.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010102

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/04/2000	411338	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

02/02/2001

Title Date

Agency, Bd or Div. Use

The Black Connection

Black Inc. CopySolutions Marathon

[illegible] CENTER PLACE OKLAHOMA CITY, OKLA 73112-9984

(405) 943-9801

122824 pay

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
[illegible]	NET 10

SHIP TO

[illegible] COUNTY
[illegible] NORTH [illegible]
[illegible] OK 731[illegible]

	PURCHASE ORDER NO	SALES PERSON	SHIPPING NO	SHIPPING DATE	INVOICE DATE
6868	T072445	OK HOUSE ACCOUN		12/04/00	12/04/00

SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
			* MAINTENANCE CONTRACT NO. 18[illegible]					
			BILLING PERIOD FROM [illegible]	[illegible]				
[illegible]		EA	[illegible] COLOR [illegible]	[illegible]	[illegible]		[illegible]	[illegible]
			SERIAL NO. [illegible]					
			SERVICE BY IRON IN JEFFERSON [illegible]					
			DOES NOT INCLUDE SUPPLIES.	[illegible]				

7306745 78

RECEIVED
DEC 14 2000
Personal Health Finance

T072445 | 000135NW9V
PURCHASE DOCUMENT | ACCOUNT NO
[illegible] | 400 BT 11
COMPLETE PARTIAL | FUND NO.
[illegible] | 3312 A-X
MATH CHECKED | OBJECT CODE
CLAIM ENTERED | CLAIM NUMBER
[illegible] | 1-31-01
APPROVED | DATE

42000

[illegible] MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
[illegible] NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
[illegible] SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

Financial Management Service

Return#: 14559

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To:

Personal Health

Vendor Name: The RK Black Connection

Vendor Number:

Invoice Number 411338 **Invoice Date:** 12/4/00 **Amount** $174.00

Order Number T072445 **Audited By** Bonnie Hartzell **Date Rejected:** 12/14/00

Funding

- ☐ Funding Not Indicated
- ☐ Does Not Match Encumbrance
- ☐ Invalid Fund
- ☐ Invalid Account
- ☐ Invalid Sub-Activity
- ☐ Invalid Object Code

Signature

- ☐ Vendor Signature
- ☐ Supervisor Signature
- ☐ Funding Block Signature

Verify The Following:

- ☐ Verify Vendor FEI #
- ☐ Verify Order #

Not Enough Allotment:

- ☐ 1st Quarter Allotment Insufficient
- ☐ 2nd Quarter Allotment Insufficient
- ☐ 3rd Quarter Allotment Insufficient
- ☐ 4th Quarter Allotment Insufficient

Need Additional Information:

- ☐ Certified Invoice Copy
- ☐ Proof of Delivery
- ☐ Notary Seal Missing
- ☐ Notary Signature Missing
- ☐ Notary County or State Incomplete
- ☐ Notary Expired (Not Valid)
- ☐ Changes Need Justification
- ☐ Changes Need Authorizing Initials
- ☐ Item Not Found

Mathematical Errors:

- ☐ Calculations Inaccurate
- ☐ Cross Footing Inaccurate
- ☐ Price Discrepancy

Encumbrance Problem:

- ☐ Invoice Exceeds Contract
- ☐ Invoice Exceeds Encumbrance
- ☐ Order Finalled

Required Dates:

- ☐ Invoice Date Prior to Date of Service
- ☐ Notary Date Prior to Date of Invoice
- ☐ Notary Date Prior to Date of Service

Other Remarks or Comments:

For your approval

Division Finance Area Comments

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DEC 14 2000
Personal Health Finance

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2001 JAN 31 A 10:36
FINANCIAL MANAGEMENT

Please Return This Document To Financial Management

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	122825

FOR AGENCY USE
WARRANT # 7708021 DATE: 02/06/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	932000000	174.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1 2 2 8 2 5

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No	TOTAL AMOUNT $	
007		OSF-AUDITED BY	174.00

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010202

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
01/10/2001	415686	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

02/02/2001

Title Date

Agency, Bd or Div. Use

The RKBlack Connection

RK Black Inc. | Copy Solutions | Macintosh

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
-15888	NET 10

SHIP VIA:

PROCUREMENT
JAN 16 2001
RECEIVED

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 7311?-1?

ACCOUNT #	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
2716868	T072445	OK HOUSE ACCOUN		1/10/01	1/10/01

ORD.	SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
				* MAINTENANCE CONTRACT NO. 18330					
				BILLING PERIOD FROM 2/2/01 THROUGH 3/1/01					
1	1		EA	AFICIO COLOR 3006	RICOH EPG	174.00		174.00	174.00
				SERIAL NO. 0100100116					
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
				DOES NOT INCLUDE SUPPLIES. RCV					
						SUBTOTAL			174.00
						FREIGHT			.00
						SALES TAX			.00
									174.00

73067457B

T072445 PURCHASE DOCUMENT
COMPLETE | 0000 PARTIAL
42000 SCU ACTIVITY
MATH | ENTERED
DOES NOT INCLUDE ACCOUNT NO.
400 BT 11 FUND NO.
3372A-X ORGN. CODE
CLAIM NUMBER
INVOICE APPROVED | DATE

000135NW97

FINANCIAL MANAGEMENT
JAN 16 P 4:44
RECEIVED

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	126483

FOR AGENCY USE
WARRANT # 7824178 DATE: 03/12/2001

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1
2
6
4
8
3

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	000000000	174.00

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	174.00
008		OSF AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010302

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/09/2001	419486	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/08/2001

Title Date

Agency, Bd or Div. Use

The KBlack Connection

Black Inc. COPYSOLUTIONS Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
[illegible]	NET 10

SHIP VIA:

126700

730674578

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV.
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 7311[illegible]

	PURCHASE ORDER NO	SALES PERSON	SHIPPING NO	SHIPPING DATE	INVOICE DATE
16868	T072445	OK HOUSE ACCOUN		2/09/01	2/09/01

SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
			* MAINTENANCE CONTRACT NO. 18330 BILLING PERIOD FROM 3/2/01 THROUGH 4/1/01					
1		EA	MPIC 1010 COLOR 3000 SERIAL NO. 3100100116 SERVICE BY IRON IN JEFFERSON CITY. 573-556-2013 DOES NOT INCLUDE SUPPLIES. RCV	RICOH EPG	174.00		174.00	1[illegible]
								1[illegible]

PROCUREME[illegible]

FEB 14 2001

RECEIVED

730674578

T072445 PURCHASE DOCUMENT	000132 NW97 ACCOUNT NO.
COMPLETE / ✓008 PARTIAL	400 BF11 FUND NO.
42000 SUB ACTIVITY	3312 A-X OBJECT CODE
✓ MATH / ENTERED	CLAIM NUMBER
Pal INVOICE APPROVED	03-08-001 DATE

R MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
S NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
S SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance ▶ 174.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	131456

FOR AGENCY USE
WARRANT # 7987908 DATE: 04/27/2001

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

ACCOUNT	SUBACTIVITY	OBJECT	CEDA	AMOUNT
000135	42000	3312	937730000	174.00

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	
011		174.00	

ONE-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY) 20010402

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/19/2001	424267	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

04/24/2001
Date

Agency, Bd or Div. Use

The KBlack Connection

Black Inc. CopySolutions Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
424267	NET 10

SHIP VIA:

13145649

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
16868	T072445	OK HOUSE ACCOUN		3/19/01	3/19/01

SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
1		EA	* MAINTENANCE CONTRACT NO. 18330 BILLING PERIOD FROM 4/2/01 THROUGH 5/1/01 AFICIO COLOR 3006	RICOH EPG	174.00		174.00	174.0
			SERIAL NO. 0100100116 SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013 DOES NOT INCLUDE SUPPLIES. RCV					
						SUBTOTAL		174.0
						FREIGHT		.0
						SALES TAX		.0

RECEIVED
2001 MAR 22 P 4:04
FINANCIAL MANAGEMENT

PURCHASE DOCUMENT T072445 ACCOUNT NO. 4000SNWA
COMPLETE PARTIAL FUND NO. 200 2011
SUB ACTIVITY 42000 OBJECT CODE 3312A-K
MATH ENTERED CLAIM NUMBER
INVOICE APPROVED DATE 04-02-2001

7306745178

MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance ▶ 174.0

INVOICES PENDING CHANGE ORDER

COPY

DATE: Thursday, April 19, 2001

TO: PROCUREMENT

FROM: Sonja Fouquet 4-19-01
Budget Analyst,
Budgeting /Funding Unit
Financial Management

Please increase the R. K. Black contract. The funds are needed to cover extra copies made in October. The contract will end 4/30/01. This will allow the final invoice to pay.-SJF.

T072445
R K BLACK\COPY SOLUTIONS
7360674578
CFDA 93.200

INCREASE:

400BT11_000135NW97_42000 3312 $94.23

Financial Management Service

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To: Return #: 14889

Sonja Fouquet/Budget Analyst

Vendor Number

Vendor Name: R K Black 730674578

Invoice Number: 424267 Invoice Date: 3/19/01 Amount: $174.00

Order Number: T072445 Audited By: Patricia Farmer Date Received: 4/2/01

Funding

- ☐ Funding Not Indicated
- ☐ Does Not Match Encumbrance
- ☐ Invalid Fund
- ☐ Invalid Account
- ☐ Invalid Sub-Activity
- ☐ Invalid Object Code

Not Enough Allotment:

- ☐ 1st Quarter Allotment Insufficient
- ☐ 2nd Quarter Allotment Insufficient
- ☐ 3rd Quarter Allotment Insufficient
- ☐ 4th Quarter Allotment Insufficient

Mathematical Error:

- ☐ Calculations Incorrect
- ☐ Cross Footing Incorrect
- ☐ Price Discrepancy

Signature

- ☐ Vendor Signature
- ☐ Supervisor Signature
- ☐ Funding Block Signature

Need Additional Information:

- ☐ Certified Invoice Copy
- ☐ Proof of Delivery
- ☐ Notary Seal Missing
- ☐ Notary Signature Missing
- ☐ Notary County or State Incomplete
- ☐ Notary Expired (Not Valid)
- ☐ Changes Need Justification
- ☐ Changes Need Authorizing Initials
- ☐ Item Not Found

Encumbrance Problem:

- ☐ Invoice Exceeds Encumbrance
- ☐ Invoice Exceeds Encumbrance
- ☐ Order Expired

Verify The Following:

- ☐ Verify Vendor FEI #
- ☐ Verify Order #

Required Date:

- ☐ Invoice Date of
- ☐ Notary Date of Invoice
- ☐ Notary Date Prior to Date of Service

Other Remarks or Comments:

Amount over order. There is a balance of $79.77 left on this P. O.

Division Finance Area Comments:

Please Return This Document To Financial Management

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X077835	134103

FOR AGENCY USE
WARRANT # 8072833 DATE: 05/23/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	932340000	21.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1
3
4
1
0
3

FOR
$ 21.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant:

WARRANT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		21.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010501

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
04/17/2001	427760	21.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 21.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise.Contractor estimates must be approved by the architect or engineer in charge of the project.Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

05/16/2001

Title Date

Agency, Bd or Div. Use

PA1

The RKBlack Connection

RK Black Inc. COPYSOLUTIONS Marathon

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
427760	NET 10

SHIP VIA:

134103

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 7

730674578

ACCOUNT #	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
2716868	T072445	OK HOUSE ACCOUN		4/17/01	4/17/01

ORD.	SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE
				*MAINTENANCE CONTRACT NO. 18330				
				BILLING PERIOD FROM 5/2/01 THROUGH 6/1/01				
1	1		EA	AFICIO COLOR 3006	RICOH EPG	195.00		195.00
				SERIAL NO. 0100100116				
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013				-174.00
				DOES NOT INCLUDE SUPPLIES. RCV				
				SCMI 04/05/01 AR				
				~~T072445~~ PURCHASE DOCUMENT	L000135NW97 ACCOUNT NO.			

cm.

SUBTOTAL 21.00

Maxwell, Ronney

From: Murphy, Romain
Sent: Monday, April 30, 2001 1:29 PM
To: Maxwell, Ronney
Cc: Cadaret, Ken; Sonja Fouquet
Subject: FW: R.K. Black T072445

Funded 4-25-01

A requisition was initiated on 4/20/01 (Req # L079134)

-----Original Message-----
From: Wilson, Linda
Sent: Monday, April 30, 2001 12:42 PM
To: Murphy, Romain
Subject: FW: R.K. Black T072445

-----Original Message-----
From: Maxwell, Ronney
Sent: Monday, April 30, 2001 12:29 PM
To: Wilson, Linda
Subject: R.K. Black T072445

This is for Maintenance contract

Ricoh Aficio Color 3006 Digital Imaging
System with Optional E-300 Internal Fiery
Print Controller

It appears this purchase order ended 04/30/01, and I cannot find a new P.O.

Thanks

05/02/01 WED 07:50 FAX 405 943 7023 RK BLACK 001

Cust.No. 2716868 OKLAHOMA STATE DEPT OF OKLAHOMA CITY AR Bal. [illegible]

Inv.No	Tac	* Tdate	Amount	Paid	Balance	C/M.No	Ref	Lstpmt
111600	1 COA	111600	-174.00		-174.00		MARY SHEPPERD	11/16
424267	20 INV	31901	174.00		174.00		MAINT.#18330	
427760	20 INV	41701	195.00		195.00		MAINT.#18330	
9999904	2 S/C	43001	~~2.61~~		~~2.61~~ Removing 5/2 5-2-01		SER CHG 999990	

Credit Limit 999999

Terms NET 10 P.O. Required

Over 90	Over 60	Over 45	Over 30	Current
174.00-	.00	.00	174.00	~~197.61~~ 195.00

Do You Wish To Print C'urrent A/R, H'istory, B'oth, Or N'one N

Sales Tax .00

5/02/01 Collection Activity Inquiry 8:46

Customer: 2716868 Name: OKLAHOMA STATE DEPT OF Phone: 405-271-6868

Branch: 1 Current A/R Balance: 197.61

Contact Date	Contact Name	Init.	Promised Pmt Date	Partial Pmt Date	Next Contact Date	A/R Balance At Contact
5/02/01	RONNIE-271-9444	RW			5/24/01	197.61

Handling Status: WE WILL CALL BACK Disposition: REFER TO FILE

5-2TKED RONNIE-271-9444 EX 56324(MARY S. NO LONGER IN THIS DEPT.)FAXING HER COPY OF A/R SO SHE CAN USE THIS COA WHEN SHE WANTS TOO.424267,SHE HAS ALREADY SENT TO ACCTS.PAY.FAX-271-3037

11/16/00	BONNIE-271-4042	RW			12/19/00	94.23

Handling Status: WE WILL CALL BACK Disposition: REFER TO FILE

11-16RECEIVED WARR. TRYING TO PAY A VOIDED INV.THAT WAS BILLED WRONG,TKED MARY SHEPPERD, WILL COA ON ACCT. & FAX HER COPY OF A/R TO USE COA NEXT MONTH BILLING.FAX-271-1262.SAME # AS BRENDA/S.

2/10/00	BONNIE-271-4042	RW			2/16/00	72.10

Handling Status: WE WILL CALL BACK Disposition: REFER TO FILE

2-10BRENDA LEFT V.M. MSG. #359045,QUESTION ON MAINTS. BILLING.PUT HER IN

Display N'ext, Or E'nd: N

5-2-01
Here is a copy of my notes + copy of A/R showing you have coa (cash on acct) of $174.00 to use when you want to

Thanks,
Ruby of
R.K. Black Inc.

A FAX from

RK. Black Inc.

4111 Perimeter Center Place Oklahoma City, OK 73112

TO: Ronnie
FAX: 271-3037
PHONE: 271-9444 Ex 56324

FROM: Ruby Wilder
FAX: (405) 943-0709
PHONE: (405) 943-9804, Ex 146
DATE: 5/2/01

MESSAGE: Thanks for your help

You should have received 2 pages including this cover sheet.

THANK YOU & HAVE A GREAT DAY !!!

** AGENCY COPY ** SVC CHF: NW

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X077835	136026

FOR AGENCY USE: WARRANT # 8131536 DATE: 06/11/2001

ACCOUNT	SUB ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	000000000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1 3 6 0 2 6

FOR
$ 195.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	195.00
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010602

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/10/2001	431115	195.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3312AAAAAX 195.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

06/06/2001

Title Date

Agency, Bd or Div. Use

136036

The RKBlack Connection

RK Black Inc. COPYSOLUTIONS Hamilton

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

43115	NET 10

SHIP VIA:

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

ACCOUNT #			INVOICE DATE
2716BE8		5/10/01	5/10/01

ORD.	SHIP	B.O.	UM	DESCRIPTION	UNIT PRICE	DISC	EXT PRICE	AMOUNT
				* MAINTENANCE CONTRACT NO. 18330				
				BILLING PERIOD FROM 6/2/01 THROUGH 7/1/01				
1	1		EA	AFICIO COLOR 3006 RICOH EPG	195.00		195.00	195.00
				SERIAL NO. 0100100116				
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013				
				DOES NOT INCLUDE SUPPLIES. RCV				
				CMI 04/05/01 AR				
				SUBTOTAL				195.00
				FREIGHT				.00
				SALES TAX				.00
								195.00

FINANCIAL MANAGEMENT
2001 MAY 15 A 11:08
RECEIVED

PURCHASE DOCUMENT | ACCOUNT NO.
COMPLETE | PARTIAL | FUND NO.
SUB ACTIVITY | OBJECT CODE
MATH | ENTERED | CLAIM NUMBER
INVOICE APPROVED | DATE 06-06-2001

PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
NS SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

136036

701-5 28152 Bx 97

SVC CHF: NW

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	115671

FOR AGENCY USE

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	932000000	94.23

FOR
$ 94.23

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	94.23
004		OSF-AUDITED BY	SSJ

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 10/30/2000

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/06/2000	407662	94.23

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 331210182X 94.23

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Chief, Financial Management — Title

11/28/2000 — Date

Agency, Bd or Div. Use

MT

The [redacted]onnection

130 674 578

RK Black Inc. [redacted]

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OK [redacted]

(405) 943-9801

INVOICE

235 018

* Please pay on invoice, no statement will be sent, unless invoice becomes past due.

[redacted]

COMPLETE	PARTIAL	FUND NO.	
SUB ACTIVITY		OBJECT CODE	
MATH	ENTERED	CLAIM NUMBER	
INVOICE APPROVED		DATE	

SHIP VIA:

[redacted]TTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

SOLD

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

[redacted]

				* MAINTENANCE CONTRACT NO. 18330 BILLING PERIOD FROM 6/2/02 THROUGH 7/1/02			
1	1		EA	AFICIO COLOR 3006 RICOH EPG SERIAL NO. 0100100116 SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013 DOES NOT INCLUDE SUPPLIES. RCV CONTRACT COUNTING DEVELOPMENTS NOT COPIES. RCV 7,500 DEVELOPMENTS/1,875 COPIES PER MONTH. RCV CMI 04/09/02	210.00	210.00	210.00
						SUBTOTAL	210.00
						FREIGHT	.00
						SALES TAX	.00

RECEIVED
2002 MAY 10 P 4:40
FINANCIAL MANAGEMENT

* 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
* RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
* RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance [redacted]

Y020 168 Y022 575 Y025 502

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	116504

FOR AGENCY USE
WARRANT # 7530416 DATE: 12/07/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CEDA	AMOUNT
000135	42000	3312	000000000	174.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1 1 6 5 0 4

FOR
$ 174.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
005		174.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001230

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/03/2000	407381	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 331210182X 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

12/05/2000
Date

Agency, Bd or Div. Use

The KBlack Connection

Black Inc. CopySolutions Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

RECEIVED

2000 NOV 14 P 12:12

FINANCIAL MANAGEMENT

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
407381	NET 10

SHIP VIA:

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 73117

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
16868	10/2[illegible]	OK HOUSE ACCOUN		11/03/00	11/03/00

SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
			* MAINTENANCE CONTRACT NO. [illegible]					
			BILLING PERIOD FROM 12/2/00 THROUGH 1/1/01					
1		EA	AFICIO COLOR 5000	RICOH EPG	174.00		174.00	174.[illegible]
			SERIAL NO. [illegible]					
			SERVICE BY IRON IN JEFFERSON CITY. [illegible]					
			DOES NOT INCLUDE SUPPLIES. RCV					
			730674578 MT		SUBTOTAL			174.[illegible]
			400BT11					
			000135NW97					
			42000					
			331210182X		FREIGHT			.[illegible]
					SALES TAX			.[illegible]

MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance ▶ 174.0

174.00

Tyson, Melanie R.

From: McKay, Angela D.
Sent: Monday, November 20, 2000 2:30 PM
To: Wilson, Linda
Cc: Tyson, Melanie R.
Subject: FW: PO#T072445-Invoice pending

-----Original Message-----
From: Tyson, Melanie R.
Sent: Monday, November 20, 2000 1:42 PM
To: McKay, Angela D.
Subject: PO#T072445-Invoice pending

I have an invoice from RK Black. It is for a maintenance contract. The billing period is from 12/2/00 through 01/01/2001. My question is, does RK Black bill for services in advance or do I need to hold this invoice until 12/2/00?
Thanks.

Tyson, Melanie R.

From: Tyson, Melanie R.
Sent: Monday, November 20, 2000 1:42 PM
To: McKay, Angela D.
Subject: PO#T072445-Invoice pending

I have an invoice from RK Black. It is for a maintenance contract. The billing period is from 12/2/00 through 01/01/2001. My question is, does RK Black bill for services in advance or do I need to hold this invoice until 12/2/00?
Thanks.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X067820	128858

FOR AGENCY USE
WARRANT # 7918304 DATE: 04/09/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3426	932000000	50.00

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	49.50
001		OSF-AUDITED BY	

CLAIM OF:
SOUTH CENTRAL INDUSTRIES, INC
731138726

FOR
$ 49.50
AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant

WARRENT (LOCATOR NO.

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010330

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/30/2001	0003344	49.50

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3426AAAAAX 50.00

J/E XREF:

VENDOR: SOUTH CENTRAL INDUSTRIES, INC
ADDRESS: 130 N. LOUISE
ADDRESS:
CITY/ST/ZIP: SHAWNEE OK 748023766

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

04/02/2001

Title Date

Agency, Bd or Div. Use

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	T072445	116504

FOR AGENCY USE: WARRANT # 7530416 DATE: 12/07/2000

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

1 1 6 5 0 4

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3312	000000000	174.00

FOR
$ 174.00

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	174.00
005		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001230

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO	AMOUNT
11/03/2000	407381	174.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 331210182X 174.00

J/E XREF:

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

12/05/2000
Date

Agency, Bd or Div. Use

The KBlack Connection

Black Inc. CopySolutions Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984
(405) 943-9801

RECEIVED
2000 NOV 14 P 12:12
FINANCIAL MANAGEMENT

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
40738I	NET 10

SHIP VIA:

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEPT OF HHS COUNTY
1930 NORTH ELM
NORMAN OK 73117

PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
16868	OK HOUSE ACCOUN		11/03/00	11/03/00

UP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
			* MAINTENANCE CONTRACT NO. 16868					
			BILLING PERIOD FROM 12/1/00 THROUGH 12/31/01					
		EA	MP1210 COLOR 3000	RICOH EPG	174.00		174.00	174.00
			SERIAL NO. V1020800110					
			SERVICE BY IRON IN JEFFERSON CITY. 573-636-6616					
			DOES NOT INCLUDE SUPPLIES. REV					
			730674578 MT			SUBTOTAL		174.00
			400BT11					
			000135NW97					
			42000					
			331210182X			FREIGHT		.00
						SALES TAX		.00

MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance ▶ 174.00

174.00

Tyson, Melanie R.

From: Tyson, Melanie R.
Sent: Monday, November 20, 2000 1:42 PM
To: McKay, Angela D.
Subject: PO#T072445-Invoice pending

I have an invoice from RK Black. It is for a maintenance contract. The billing period is from 12/2/00 through 01/01/2001. My question is, does RK Black bill for services in advance or do I need to hold this invoice until 12/2/00?
Thanks.

Tyson, Melanie R.

From: McKay, Angela D.
Sent: Monday, November 20, 2000 2:30 PM
To: Wilson, Linda
Cc: Tyson, Melanie R.
Subject: FW: PO#T072445-Invoice pending

-----Original Message-----
From: Tyson, Melanie R.
Sent: Monday, November 20, 2000 1:42 PM
To: McKay, Angela D.
Subject: PO#T072445-Invoice pending

I have an invoice from RK Black. It is for a maintenance contract. The billing period is from 12/2/00 through 01/01/2001. My question is, does RK Black bill for services in advance or do I need to hold this invoice until 12/2/00?
Thanks.

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X067820	128858

FOR AGENCY USE
WARRANT # 7918304 DATE: 04/09/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3426	932000000	50.00

CLAIM OF:
SOUTH CENTRAL INDUSTRIES, INC
731138726

FOR
$ 49.50

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant

WARRENT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	49.50
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010330

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/30/2001	0003344	49.50

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3426AAAAAX 50.00

J/E XREF:

VENDOR: SOUTH CENTRAL INDUSTRIES, INC
ADDRESS: 130 N. LOUISE
ADDRESS:
CITY/ST/ZIP: SHAWNEE OK 748023766

Attach all invoices or contract estimates to the reverse side of this jacket. Multuple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

04/02/2001
Date

Agency, Bd or Div. Use

128858 pr

SOUTH CENTRAL INDUSTRIES, INC.

P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

731138724

Customer's Order No. X067820 Phone No. _____ Date 3-30-01

Name Okla State Department of Health

Address 1000 N.E 10th Street OKC, OK

SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT	
1cs	0475-41-44-150	50.00	50	00
	Latex PF Ultra			
	Medium			
	Thank You!			
	JS 011 150			
			50	00
	Minus 1% levy	~~TAX~~		50
		TOTAL	45	50

3-30

X067820 PO # or CT #	000135NW97 Account Number
100 / / Complete-Partial	400BT11 Fund Number
42000 Sub-Activity	3426A-X Object Code
/ / Math Entered	Claim Number
PReam Inv Funded By	4-2-01 Date

All claims and returned goods MUST be accompanied by this bill.

0003344

Rec'd by _____

GS-209-2

PRINTED IN U.S.A.

I certify this to be the original invoice - no other invoice will be submitted - PReam 4-2-01

RECEIVED
MAR 3 0 2001
SHIPPING & RECEIVING

CV#128858

SOUTH CENTRAL INDUSTRIES, INC.

P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer's Order No. X067820 Phone No _____ Date 3-30-01

Name Okla State Department of Health

Address 1000 N.E 10th Street OKC, OK

SOLD BY	CASH	C.O.D	CHARGE	ON ACCT	MDSE. RETD	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT	
1cs	0475-41-44-150	50.00	50	00
	Latex PF Ultra			
	Medium			
	Thank You!			
			50	00
	Minus 1% Levy			50
		TOTAL	45	50

Paid Already

RECEIVED
2001 APR -5 AM 10:46
FINANCIAL MANAGEMENT

X067820
PURCHASE DOCUMENT
ACCOUNT NO.
COMPLETE PARTIAL
FUND NO
SUB ACTIVITY
OBJECT CODE
MATH ENTERED
CLAIM NUMBER
INVOICE APPROVED
DATE

All claims and returned goods MUST be accompanied by this bill.

0003344

Rec'd by _____

GS-209-2

PRINTED IN U.S.A.

SOUTH CENTRAL INDUSTRIES, INC.

P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer's Order No. X067820 Phone No. _____ Date 3-30-01

Name OKla State Department of Health

Address 1000 N.E 10th Street OKC, OK

SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT	

QUAN.	DESCRIPTION	PRICE	AMOUNT	
1cs	0475-41-44-150.	50.00	50	00
	Latex PF Ultra			
	Medium			
	Thank You!			
			50	00
	Minus 1% levy	Tax		50
		TOTAL	49	50

All claims and returned goods MUST be accompanied by this bill.

0003344

Rec'd by _____

GS-209-2

PRINTED IN U.S.A.

RECEIVED
MAR 3 0 2001
SHIPPING & RECEIVING

I certify this to be a copy of the original invoice
Original lost 4-24-2001 jpf

SOUTH CENTRAL INDUSTRIES, INC.

P.O. Box 3766
130 N. Louisa
SHAWNEE, OK 74801-3766
(405) 275-3851

Customer's Order No. X067820 Phone No. _____ Date 3-30-01

Name OKla State Department of Health

Address 1000 N.E. 10th Street OKC, OK

SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT	

QUAN.	DESCRIPTION	PRICE	AMOUNT	
1cs	0495-41-44-150	50.00	50	00
	Latex PF Ultra			
	Medium			
	Thank You			
			50	00
	Minus 1% Very			50
		TOTAL	49	50

All claims and returned goods MUST be accompanied by this bill.

0003344 73113872 Rec'd by Rcd 4/2/01 NCH

GS-209-2

PURCHASE DOCUMENT X067820 ACCOUNT
COMPLETE PARTIAL FUND NO.
SUB ACTIVITY OBJECT CODE
MATH ENTERED CLAIM NUMBER
INVOICE APPROVED jpf DATE 04-24-2001

PRINTED IN U.S.A.

RECEIVED
MAR 30 2001
SHIPPING & RECEIVING

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X065395	128523

FOR AGENCY USE
WARRANT # 7957030 DATE: 04/19/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CEDA	AMOUNT
000135	42000	3721	932000000	5,710.00

CLAIM OF:
ESA, INC
042447948

FOR
$ 5,710.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date _____
Claimant: _____

WARREN (LOCATOR NO.)

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	5,710.00
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010326

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/20/2001	574997	5,710.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3721AAAAAX 5710.00

J/E XREF:

VENDOR: ESA, INC
ADDRESS: 22 ALPHA RD
ADDRESS:
CITY/ST/ZIP: CHELMSFORD MA 018244171

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/28/2001

Title Date

Agency, Bd or Div. Use

	Date	Number
INVOICE	03/20/01	574997
Sales Order	03/19/01	221400

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Ship Via UPS
F.O.B. FACTORY
Ship Term
Bill of Lading

128523

Bill To:
10565 OKLAHOMA STATE DEPARTMENT OF
ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1229

Ship To:
OKLAHOMA STATE DEPARTMENT OF
1000 NORTHEAST 10TH STREET
ATTN; SHIPPING & RECEIVING
OKLAHOMA CITY, OK 73117-1299

ROMAIN MURPHY 405-271-4770X 56756 LC

Payment Terms NET 30 | Sales Rep # 36 | Cust PO X065395

Line	Qty	Part Number	Description	Unit Price	Value
1	25	70-2233	LEADCARE BLOOD LEAD TEST KIT	220.0000	5500.00
2	6	70-3440	LEADCARE CONTROL KIT	35.0000	210.00

042447948

3-26-01
X065395 000135NW97
001 400BT11
42000 3721A-X

PReam 3-28-01

freight not authorized on purchase order PReam

Sale Amount	5710.00
Misc Amount	.00
Sales Tax	.00
Freight	~~37.63~~
TOTAL	~~5747.63~~ 5710.00

RECEIVED

IMPORTANT: THIS SALE SHALL BE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE SIDE

ESA, Inc. & ESA International, Inc.
22 Alpha Road
Chelmsford, MA 01824-4171
Telephone: (978) 250-7000
Fax: (978) 250-7090

Order # 03/20/01 221660
03/19/01

Ship Via UPS
F.O.B. FACTORY
Ship Term
Bill of Lading

1000 N.E. 10TH STREET

DEPARTMENT OF
1000 NORTHEAST 10TH STREET
ATTN: SHIPPING & RECEIVING
OKLAHOMA CITY, OK 73117-1299

ROMAIN MURPHY 405-271-4770X 56756 LC

Payment Terms
NET 30

Sales Rep # 36

Cust PO
X065395

	Quantity	Item No.	Description	Ship Date	Shipped
1	25 EA	70-2233	LEADCARE BLOOD LEAD TEST KIT	03/19/01	25
		STOCKROOM: MAIN	LOCATION: SHIP		
2	6 EA	70-3440	LEADCARE CONTROL KIT	03/19/01	6
		STOCKROOM: MAIN	LOCATION: FRIG		

BC0103-01

RECEIVED
MAR 2 6 2001
SHIPPING & RECEIVING

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X045940	123654

FOR AGENCY USE
WARRANT # 7737651 DATE: 02/14/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	3911	000000000	390.00

CLAIM OF:
UNIV OF OK HEALTH SCIENCE CNT
736017987

FOR
$ 390.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001	YES	390.00

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010108

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
01/17/2001	01172001	390.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 3911AAAAAX 390.00

J/E XREF:

VENDOR: UNIV OF OK HEALTH SCIENCE CNT
ADDRESS: FINANCIAL ACCT, SCB ROOM 224M
ADDRESS: P.O. BOX 26901
CITY/ST/ZIP: OKLAHOMA CITY OK 73190

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

02/09/2001

Title Date

Agency, Bd or Div. Use

123654 pay

INVOICE

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER
INSTITUTE FOR ENVIRONMENTAL MANAGEMENT
POST OFFICE BOX 26901, ROOM 413
OKLAHOMA CITY, OKLAHOMA 73190
(405) 271-2070

Billed To:

Oklahoma State Department of Health
ATTN: Accounts Payable
1000 Northeast 10th Street
Oklahoma City, Oklahoma 73117-1299

Date: **January 17, 2001**
PO: **X045940**

REQUEST OF PAYMENT

Item No.	Quantity	Unit	Description of Materials	Unit Cost	Total
1	2	Ea	Registration Fee for Mr. Preston L. Ross and Susan A. Waldron to attend the LBP Risk Assessor Refresher Course, January 08, 2000, Grand Gateway, Commerce (see attachment).	$ 195.00	$ 390.00

TOTAL AMOUNT DUE: $ 390.00

0-001
42000

REMIT PAYMENT TO:

University of Oklahoma Health Sciences Center
Institute for Environmental Management
College of Public Health
Post Office Box 26901, Room 413
Oklahoma City, Oklahoma 73190

X045940 PURCHASE DOCUMENT
000135NW97 ACCOUNT NO
✓ 001 PARTIAL
400BT11 FUND NO
42000 ACTIVITY
3911A-X
✓ ENTERED
123654 CLAIM NUMBER
02-09-2001 INVOICE APPROVED DATE

ORG	FUND	PROGRAM	PROJECT/GRANT
CPH501	CLNOP	00024	CPHAINST

Agency #770

Certificate

I certify that the above charges is just, correct, and that payment has not been received.

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Mark R Cox 1-18-01

MARK R. COX, PH.D., Interim Director
Institute for Environmental Management

Invoice Prepared by Carolyn J. Scott
(405) 271-2070 Ext. 46771

Taxpayer Identification Number: 73-6017987

1. Vendor's Office Copy

Page 1

State of Oklahoma
State Department of Health
Purchase Order

PO# X045940

BUYER - ROMM (405-271-6617)

Date Issued:	Agency Reqn.#:	Terms:	Delivery Date:
12/11/00 Reqn.#: L046945	01-02649	NET	01/01/2001

To: 736017987ENV
OUHSC INST FOR ENVIRONMENTAL MGMT
801 NE 13TH
OKLAHOMA CITY OK 73190

Ship To: 34001
OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: SHIPPING & RECEIVING
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

Charge & Invoice To: 34000
OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

Item	Quantity	Unit	Commodity Code	Description	Unit Price	Amount
001	2.00	EA	0924-40	Registration Fees for LPB Risk Assessor Refresher .Course for Ottawa CHD (ATSDR) Lead Poisoning .Prevention Program staff. .Attendees: Susan Waldron; Preston Ross .1/8/01, Grand Gateway, Commerce .	195.000000	390.00

Total Amount $390.00

TERMS:

Agency contact: Procurement 405/271-4042
.Program Contact: Pam Perry 405/271-4470 x 56825
.

Prices exclusive of Federal and State Taxes. Prices are FOB destination unless stated otherwise.
VENDORS READ AND FOLLOW CLOSELY:

1. This order void one year from date of issuance.
2. The above order is issued in conformity with your quotation and constitutes a contract.
3. If payment is received in excess of 45 days after submitting proper invoice, vendor may be be entitled to claim interest penalty. For a copy of these regulations contact OFFICE OF STATE FINANCE Room 122, State Capitol Bldg, OKC, OK. 73105

signed
Director/Designee
title

REGISTRATION FORM

NAME Preston (First) L. (Middle) Ross (Last)

SOCIAL SECURITY NUMBER PERSONAL IDENTIFIER(S) REDACTED

HOME ADDRESS PERSONAL IDENTIFIER(S) REDACTED

CITY _____ STATE _____ _____

HOME PHONE NUMBER PERSONAL IDENTIFIER(S) REDACTED

HOME FAX NUMBER ( ) - HOME E-MAIL PERSONAL IDENTIFIER(S) REDACTED

EMPLOYER Ottawa CHD

BUSINESS ADDRESS 1930 N. Elm

CITY Miami STATE OK ZIP 74354

BUSINESS TELEPHONE NUMBER (918) 540-2481

PAGER ( ) - MOBILE (918) 533-2118

BUSINESS FAX NUMBER (918) 540-2481 BUSINESS E-MAIL PrestonR@health.state.ok.us

COURSE		Date	LOCATION/CITY	COST
X	LBP Risk Assessor Refresher	1/08	Grand Gateway, Commerce	$195.00

Class will be taught from 8 to 5 each day. Anyone arriving after 8:30 will not be admitted to class. There are ***no*** refunds given once class begins. ***Payment must be received before class begins.*** No one will be allowed to take any course without full payment prior to the beginning of each class.

Checks must be payable to: **OUHSC***
And mailed to:
OUHSC
Institute for Environmental Management
Attn: Dr. Mark Cox
College of Public Health
P.O. Box 26901
Oklahoma City, OK 73190

For questions call:
Neil Brown (405) 844-8176
Michael Burnside (918) 357-5006
Dr. Mark Cox (405) 271-2070

Registration forms may be faxed:
Attn: Carolyn Scott
(405) 271-1971 FAX

***P.O. pending (will be delivered to site on class day)**

REGISTRATION FORM

NAME Susan (First) A. (Middle) Waldron (Last)

SOCIAL SECURITY NUMBER _

CITY __ PERSONAL IDENTIFIER(S) REDACTED STATE PERSONAL IDENTIFIER(S) REDACTED

HOME PHONE NUMBER

HOME FAX NUMBER ( ) N/A PERSONAL IDENTIFIER(S) REDACTED HOME E-MAIL N/A

EMPLOYER Ottawa County Health Department

BUSINESS ADDRESS 1930 N. Elm

CITY Miami STATE OK ZIP 74354

BUSINESS TELEPHONE NUMBER (918) 540-2481

PAGER (918) 220-6511 MOBILE (918) 533-0999

BUSINESS FAX NUMBER (918) 540-2481 BUSINESS E-MAIL: SusanAW @health.state.ok.us

COURSE	Date	LOCATION/CITY	COST
_X_ LBP Risk Assessor Refresher	1/08	Grand Gateway, Commerce	$195.00

Class will be taught from 8 to 5 each day. Anyone arriving after 8:30 will not be admitted to class. There are ***no*** refunds given once class begins. ***Payment must be received before class begins.*** No one will be allowed to take any course without full payment prior to the beginning of each class.

Checks must be payable to: **OUHSC***
And mailed to:
OUHSC
Institute for Environmental Management
Attn: Dr. Mark Cox
College of Public Health
P.O. Box 26901
Oklahoma City, OK 73190

For questions call:
Neil Brown (405) 844-8176
Michael Burnside (918) 357-5006
Dr. Mark Cox (405) 271-2070

Registration forms may be faxed:
Attn: Carolyn Scott
(405) 271-1971 FAX

*** PENDING P.O. (will be delivered to site on class day)**

Farmer, Pat A.

From: Perry, Pamela S.
Sent: Monday, February 05, 2001 4:34 PM
To: Farmer, Pat A.
Subject: RE: Verification of attendance

They did attend so you can pay the invoice. Tks.

-----Original Message-----
From: Farmer, Pat A.
Sent: Wednesday, January 24, 2001 3:34 PM
To: Perry, Pamela S.
Subject: Verification of attendance

Pam could you tell me if Mr. Preston L. Ross and Susan A. Waldron attended the LBP Risk Assessor Refresher Course held on January 08, 2001. The P.O. Number is X045940. Thanks

Farmer, Pat A.

From: Perry, Pamela S.
Sent: Monday, February 05, 2001 3:17 PM
To: Farmer, Pat A.
Subject: RE: Verification of attendance

As I told you I am still waiting for verification of attendance on the two people. They are both employed at Ottawa County. Hopefully I will have an answer for you later today or maybe tomorrow.

-----Original Message-----
From: Farmer, Pat A.
Sent: Wednesday, January 24, 2001 3:34 PM
To: Perry, Pamela S.
Subject: Verification of attendance

Pam could you tell me if Mr. Preston L. Ross and Susan A. Waldron attended the LBP Risk Assessor Refresher Course held on January 08, 2001. The P.O. Number is X045940. Thanks

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	118573

FOR AGENCY USE
WARRANT # 7586675 DATE: 12/28/2000

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	939190000	710.42

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

1 1 8 5 7 3

FOR
$ 710.42

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		710.42

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001130

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/01/2000	11/2000	710.42

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 710.42

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise.Contractor estimates must be approved by the architect or engineer in charge of the project.Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

12/22/2000
Date

Agency, Bd or Div. Use

Ker
mcu
12/14

118573
MT

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

RECEIVED
DEC 1 8 2000
Personal Health Finance

INVOICE

RECEIVED
DEC 0 8 2000
OTTAWA COUNTY HEALTH DEPT.

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 12-1-00

Billing Period: Nov. 16 through Nov. 30, 2000

Purchase Order #: X041428

CONTRACTOR Representative:
Bob Walker, Superintendent
918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	28.5	Hour	Teachers Aides - reading and math activities and assistance	8.00	228.00
002	28.5	Hour	Teachers Aides - speech language remediation	8.00	228.00
003	7	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	56.00
004	1	Monthly	Fringe Benefits (Health Insurance)	198.42	198.42
				Total Amount	710.42

Total number of students served during this billing period: 160

Copies of Time and Effort sheets that reflect ea[illegible] acitivity code: Attached

RECEIVED
DEC 1 4 2000
CONTRACT COORDINATOR

X041428 000135NW97
001 400BT11
✓ 42000 5511 A-X
12/15/00

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
11/16/00	4	4		8
11/17/00	4	4		8
11/20/00	4	4		8
11/21/00	4	4		8
11/27/00	4	4		8
11/28/00	4	4		8
11/29/00	4	4		8
11/30/00	1/2	1/2	7	8

Total Time Sheet Hours	64

Employee signature: Joann Roberts **Date:** 11-30-00

Supervisor signature: Kimberly D. Pace **Date:** 12/1/00

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	121844

FOR AGENCY USE
WARRANT # 7678947 DATE: 01/29/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	000000000	1,294.42

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 1,294.42

AGAINST
Agency, Board, Comm., Dept. Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date _____
Claimant: _____

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	1,294.42
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001230

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/01/2000	12302000	1,294.42

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 1294.42

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

01/24/2001
Date

Agency, Bd or Div. Use

121844

MCH MONTHLY EXPENDITURE REPORT

CONTRACTOR:	Picher - Cardin Public Schools
LICENSE # & EXP. DATE:	
ADDRESS:	PO BOX 280 715 West "A" Street, Picher OK 74360
P.O. NUMBER:	X041428
CONTRACT PERIOD:	11/15/00 through 09/30/01
SERVICE PROVIDED:	Teacher Aide
PROGRAM DIRECTOR:	KEN CADARET
PROJECT AREA:	Lead Poisoning Prevention
CURRENT INVOICE PERIOD:	Dec-00

1/12/01 DATE OF INVOICE
18.18% PERCENT OF BUDGET YEAR

	LINE ITEM BUDGET	CURRENT EXPENSE	EXPENDITURE YEAR TO DATE	LINE ITEM % EXPENDED	BUDGET	REMAINING BALANCE
1.	Teacher Aide - reading & math	$484.00	$0.00	0.00%	$7,744.00	$7,744.00
2.	Teacher Aide - speech language	$484.00	$0.00	0.00%	$7,744.00	$7,744.00
3.	Teacher Aide - Lead poisoning prev.	$128.00	$0.00	0.00%	$1,920.00	$1,920.00
4.	Fringe Benefits	$198.42	$0.00	0.00%	$4,592.00	$4,592.00
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
	TOTAL	$1,294.42	$0.00	0.00%	$22,000.00	$22,000.00

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

INVOICE

X041428 PURCHASE DOCUMENT
000135 ACCOUNT NO.
COMPLETE PARTIAL
FUND NO.
MATH CHECKED
OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
01-24-2001 DATE

42 000

RECEIVED
JAN 08 2001
OTTAWA COUNTY HEALTH DEPT.

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 12-1-00

Billing Period: 12-1-00 through 12-30-00

Purchase Order #: X041428

CONTRACTOR Representative:
Bob Walker, Superintendent
918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	60 1/2	Hour	Teachers Aides - reading and math activities and assistance	8.00	484.00
002	60 1/2	Hour	Teachers Aides - speech language remediation	8.00	484.00
003	16	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	128.00
004	1	Monthly	Fringe Benefits (Health Insurance)	198.42	198.42
				Total Amount	1294.42

Total number of students served during this billing period: 160

JAN 12

Copies of Time and Effort sheets that reflect each duty as an activity code: Attached

RECEIVED
JAN
MCH CONTRACT COORDINATOR

approved

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
12/01/00	4	4		8
12/04/00	4	4		8
12/05/00	4	4		8
12/06/00	4	4		8
12/07/00	4	4		8
12/08/00	4	4		8
12/11/00	4	4		8
12/12/00	4	4		8
12/13/00	4	4		8
12/14/00	4	4		8
12/15/00	4	4		8
12/18/00	4	4		8
12/19/00	4	4		8
12/27/00	4	4		8
12/28/00			8	8
12/29/00			8	8

Total Time Sheet Hours	128 ✓

Employee signature: Joann Roberts **Date:** 12-29-00

Supervisor signature: Ron Walker **Date:** 1/3/01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Mycal K. Morton

Date	001 Hours	002 Hours	003 Hours	Total hours
12-27-00	4 1/2	1		5 1/2
12-28-00		3 1/2		3 1/2
				1

Total Time Sheet Hours 9

Employee signature: Mycal Morton **Date:** 01-02-01

Supervisor signature: [signature] **Date:** 01/3/01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC, CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	124685

FOR AGENCY USE
WARRANT # 7771349 DATE: 02/23/2001

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

1 2 4 6 8 5

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	000000000	3,212.84

FOR
$ 3,212.84

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order

Partial No.	Final No.	TOTAL AMOUNT $	3,212.84
003		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY) 20010131

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES.

INVOICE DATE	INVOICE NO.	AMOUNT
02/01/2001	01312001	3,212.84

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 3212.84

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

02/20/2001

Title Date

Agency, Bd or Div. Use

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

INVOICE

RECEIVED
FEB 06 2001
OTTAWA COUNTY HEALTH DEPT

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 2/1/01

Billing Period: 1/2/01 through 1/31/01

Purchase Order #: X041428

CONTRACTOR Representative:

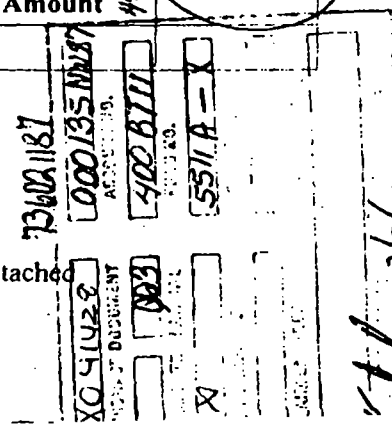
Bob Walker, Superintendent

918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	152	Hour	Teachers Aides - reading and math activities and assistance	8.00	1216.00
002	152	Hour	Teachers Aides - speech language remediation	8.00	1216.00
003	48	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	384.00
004	2	Monthly	Fringe Benefits (Health Insurance)	198.42	396.84
				Total Amount	$3,212.84

Total number of students served during this billing period: 160

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached



Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
1-2-01	4	4		8
1-3-01	4	4		8
1-4-01	4	4		8
1-5-01	4	4		8
1-8-01	4	4		8
1-9-01	4	4		8
1-10-01	4	4		8
1-11-01	4	4		8
1-12-01			8	8
1-15-01	4	4		8
1-16-01	4	4		8
1-17-01	4	4		8
1-18-01	4	4		8
1-19-01			8	8
1-22-01	4	4		8
1-23-01	4	4		8
1-24-01	4	4		8
1-25-01	4	4		8
1-26-01			8	8
1-29-01	4	4		8
1-30-01	4	4		8
1-31-01	4	4		8

Total Time Sheet Hours 176

Employee signature: Joann Roberts **Date:** 1-31-01

Supervisor signature: B Z Wells **Date:** 2/1/01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Myca K. Morton

Date	001 Hours	002 Hours	003 Hours	Total hours
01-02-01	4	4		8
01-03-01	4	4		8
01-04-01	4	4		8
01-05-01	4	4		8
01-08-01	4	4		8
01-09-01	4	4		8
01-10-01	4	4		8
01-11-01	4	4		8
01-12-01			8	8
01-15-01	4	4		8
01-16-01	4	4		8
01-17-01	4	4		8
01-18-01	4	4		8
01-19-01			8	8
01-22-01	4	4		8
01-23-01	4	4		8
01-24-01	4	4		8
01-25-01	4	4		8
01-26-01			8	8
01-29-01	4	4		8
01-30-01	4	4		8
01-31-01	4	4		8

Total Time Sheet Hours 176

Employee signature: Myca K. Morton **Date:** 02-01-01

Supervisor signature: Bill Wells **Date:** 2/1/01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	128398

FOR AGENCY USE: WARRANT # 7891809 DATE: 03/30/2001

ACCOUNT	SUBACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	932000000	2,956.84

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 2,956.84

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR NO.)

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	2,956.84
004		OSF AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY) 20010228

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/01/2001	02282001	2,956.84

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 2956.84

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

Date 03/27/2001

Agency, Bd or Div. Use

128398 pd

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

INVOICE

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 3/1/01

Billing Period: February 1 through February 28, 2001

Purchase Order #: X041428

CONTRACTOR Representative:
Bob Walker, Superintendent
918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	144	Hour	Teachers Aides - reading and math activities and assistance	8.00	1152.00
002	144	Hour	Teachers Aides - speech language remediation	8.00	1152.00
003	32	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	256.00
004	2	Monthly	Fringe Benefits (Health Insurance)	198.42	396.84
				Total Amount	2,956.84

X041428 PURCHASE DOCUMENT
[illegible] ACCOUNT NO.
COMPLETE 1004 PARTIAL
400 BILL FUND NO.
42000 SUB ACTIVITY
5511 A-X OBJECT CODE
MATH ENTERED
CLAIM NUMBER
INVOICE APPROVED 03-27-2001

Total number of students served during this billing period: 250

736021187

K-Klar 3/20/01

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
2-1-01	4	4		8
2-2-01			8	8
2-5-01	4	4		8
2-6-01	4	4		8
2-7-01	4	4		8
2-8-01	4	4		8
2-9-01			8	8
2-12-01	4	4		8
2-13-01	4	4		8
2-14-01	4	4		8
2-15-01	4	4		8
2-16-01	4	4		8
2-19-01	4	4		8
2-20-01	4	4		8
2-21-01	4	4		8
2-22-01	4	4		8
2-23-01	4	4		8
2-26-01	4	4		8
2-27-01	4	4		8
2-28-01	4	4		8

Total Time Sheet Hours 160 ✓

Employee signature: Joann Roberts **Date:** 2-28-01

Supervisor signature: Kimberly D. Pace **Date:** 2-28-01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Myra K Marlon

Date	001 Hours	002 Hours	003 Hours	Total hours
02 01 01	4	4		8
02 02 01			8	8
02 05 01	4	4		8
02-06-01	4	4		8
02 07 01	4	4		8
02 08 01	4	4		8
02 09 01			8	8
02-12-01	4	4		8
02 13 01	4	4		8
2 14 01	4	4		8
	4	4		8
02 16 01	4	4		8
02 19 01	4	4		8
02-20-01	4	4		8
02-21-01	4	4		8
02-22-01	4	4		8
02-23-01	4	4		8
02 26 01	4	4		8
02 27 01	4	4		8
02 28 01	4	4		8

Total Time Sheet Hours 160 ✓

Employee signature: Myra K Marlon **Date:** 2-28-01

Supervisor signature: Kimberly J. Pace **Date:** 2-28-01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	128398

FOR AGENCY USE: WARRANT # 7891809 DATE: 03/30/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CEDA	AMOUNT
000135	42000	5511	932000000	2,956.84

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

1 2 8 3 9 8

FOR
$ 2,956.84

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____ and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
004		2,956.84

OSF AUDITED BY:

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY) 20010228

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/01/2001	02282001	2,956.84

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 2956.84

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/27/2001

Title Date

Agency, Bd or Div. Use

128398 pd

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

INVOICE

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 3/1/01

Billing Period: February 1 through February 28, 2001

Purchase Order #: X041428

CONTRACTOR Representative:
Bob Walker, Superintendent
918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	144	Hour	Teachers Aides - reading and math activities and assistance	8.00	1152.00
002	144	Hour	Teachers Aides - speech language remediation	8.00	1152.00
003	32	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	256.00
004	2	Monthly	Fringe Benefits (Health Insurance)	198.42	396.84
				Total Amount	2,956.84

X041428 PURCHASE DOCUMENT
[illegible] ACCOUNT NO.
COMPLETE 004 PARTIAL
400 BTU FUND NO.
42000 SUB ACTIVITY
5511 A-X OBJECT CODE
MATH ENTERED
CLAIM NUMBER
INVOICE APPROVED 03-27-2001

Total number of students served during this billing period: 250

736021187

K-Blr 3/20/01

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
2-1-01	4	4		8
2-2-01			8	8
2-5-01	4	4		8
2-6-01	4	4		8
2-7-01	4	4		8
2-8-01	4	4		8
2-9-01			8	8
2-12-01	4	4		8
2-13-01	4	4		8
2-14-01	4	4		8
2-15-01	4	4		8
2-16-01	4	4		8
2-19-01	4	4		8
2-20-01	4	4		8
2-21-01	4	4		8
2-22-01	4	4		8
2-23-01	4	4		8
2-26-01	4	4		8
2-27-01	4	4		8
2-28-01	4	4		8

Total Time Sheet Hours 160 ✓

Employee signature: Joann Roberts **Date:** 2-28-01

Supervisor signature: Kimberly D. Pace **Date:** 2-28-01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Myark Marlon

Date	001 Hours	002 Hours	003 Hours	Total hours
02 01 01	4	4		8
02 02 01			8	8
02 05 01	4	4		8
02-06-01	4	4		8
02 07 01	4	4		8
02 08 01	4	4		8
02 09 01			8	8
02 12 01	4	4		8
02 13 01	4	4		8
2 14 01	4	4		8
	4	4		8
02 16 01	4	4		8
02 19 01	4	4		8
02 20 01	4	4		8
02-21 01	4	4		8
02 22 01	4	4		8
02-23-01	4	4		8
02 26 01	4	4		8
02 27 01	4	4		8
02 28 01	4	4		8

Total Time Sheet Hours 160 ✓

Employee signature: Myark Marlon **Date:** 2-28-01

Supervisor signature: Kimberly J. Pace **Date:** 2-28-01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X069364	130210

FOR AGENCY USE
WARRANT # 7947067 DATE: 04/17/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	939910000	865.00

CLAIM OF:
OTTAWA COUNTY HLTH DEPT (58)
736006404

1 3 0 2 1 0

FOR
$ 865.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant _____

WARREN LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	
001		865.00	

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001231

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/28/2001	58LG030123	865.00

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 865.00

J/E XREF:

VENDOR: OTTAWA COUNTY HLTH DEPT (58)
ADDRESS: 1930 N. ELM
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74354

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

04/12/2001
Date

Agency, Bd or Div. Use

INVOICE NUMBER 581G03-01-23

3-28-01 19
Date Prepared

NAME Ottawa COunty Health Dept. FID/SSN 73-6006404

Mailing Address (Street/Box Number) 1930 N. Elm

City Miami State OK Zip 74354 -

130210 apd

Service Date MO	DAY	YEAR	Description of Service Rendered	Units Of Svc	Price ($) Per Unit	TOTAL (Unit X $)
10	31	00	Reimburse Ottawa CHD M&O expenses			
			for Lead Grant 1st Qtr per attached			
			invoice			$865.00
					TOTAL	$865.00

STATE OF OKLAHOMA, COUNTY OF Ottawa

The undersigned (architect, contractor, supplier or engineer), of lawful age, being first duly sworn, on oath says that this (invoice, claim or contract) is true and correct. Affiant further states that the (work, services, or materials) as shown by this invoice or claim have been (completed or supplied) in accordance with the plans, specifications, orders or requests furnished the affiant. Affiant further states that (s)he has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly, to any elected official, officer or employee of the State of Oklahoma, of money or any other thing of value to obtain payment or the award of this contract.

Jane Ann Nichols by JB
Architect, Contractor, Supplier or Engineer

Subscribed and sworn to before me this 28th day of March, 2001

My commission expires:
5-27-02

Notary Public (County Clerk or Judge)

OFFICIAL USE ONLY:

X0693764	000135NW97
PO # or CT #	Account Number
001	400 BT11
Complete-Partial	Fund Number
42000	5511 A - X
Sub-Activity	Object Code
/ /	
Math Entered	Claim Number
	4-12-2001
INV Funded By	Date

APPROVED FOR PAYMENT

3-30-01
Program Supervisor

Oklahoma State Department of Health
Financial Management Service - 0102
1000 N.E. 10th St.
Oklahoma City, Oklahoma 73117-1299

OKLAHOMA STATE DEPARTMENT OF HEALTH
Financial Management Service

INVOICE

12/91 ODH FORM 8

R C SALES AD SPECIALTIES asi303321

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

Invoice

DATE	INVOICE #
10/11/00	12714

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
958	NET 10 DAYS		10/11/00	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
500	NONINVENTORY	#267 SIP-A-BABY CUP ASSORTED COLORS – IMPRINTED LIDS	1.65	825.00T
1	NONINVENTORY	SET UP	40.00	40.00T
	UPS	INCLUDED	0.00	0.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you for your business.

Total

** AGENCY COPY ** SVC CHF: NW

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	131105

FOR AGENCY USE: WARRANT # 7977537 DATE: 04/25/2001

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

1 3 1 1 0 5

ACCOUNT	SUB ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	000000000	2,572.84

FOR
$ 2,572.84

AGAINST

Agency, Board, / Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARRANT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	2,572.84
005		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010331

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
04/01/2001	250	2,572.84

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 2572.84

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

04/20/2001
Date

Agency, Bd or Div. Use

13/105 PA

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

INVOICE

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 4/1/01

Billing Period: 3/1/01 through 3/31/01

Purchase Order #: X041428

CONTRACTOR Representative:

Bob Walker, Superintendent

918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	120	Hour	Teachers Aides - reading and math activities and assistance	8.00	960.00
002	120	Hour	Teachers Aides - speech language remediation	8.00	960.00
003	32	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	256.00
004	2	Monthly	Fringe Benefits (Health Insurance)	198.42	396.84
				Total Amount	$2,572.84

736021187

X041428 PURCHASE DOCUMENT
000135 ACCOUNT NO.
COMPLETE 005 PARTIAL
400 BTII FUND NO.
42000 SUB ACTIVITY
5311A-X OBJECT CODE
MATH ENTERED
CLAIM NUMBER
04-20-2001 APPROVED DATE

K- Cardin 4/2/01

Total number of students served during this billing period: 250

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached

APR - 6

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X069364	131188

FOR AGENCY USE: WARRANT # 7977576 DATE: 04/25/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	841810000	3,024.59

CLAIM OF:
OTTAWA COUNTY HLTH DEPT (58)
736006404

1 3 1 1 8 8

FOR
$ 3,024.59

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant _____

WARREN LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	
002		3,024.59	

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20001231

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/26/2001	58LG020121	3,024.59

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 3024.59

J/E XREF:

VENDOR: OTTAWA COUNTY HLTH DEPT (58)
ADDRESS: 1930 N. ELM
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74354

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise.Contractor estimates must be approved by the architect or engineer in charge of the project.Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

04/23/2001
Date

Agency, Bd or Div. Use

131188 Pd

INVOICE NUMBER 58LG0201-21

2-26-01, 19 ___
Date Prepared

NAME Ottawa County Health Dept. ✓ FID/SSN 73-6006404

Mailing Address (Street/Box Number) 1930 North Elm

City Miami State OK Zip 74354 -

Service Date MO	DAY	YEAR	Description of Service Rendered	Units Of Svc	Price ($) Per Unit	TOTAL (Unit X $)
12	31	01	Reimburse Ottawa CHD M&O expenses			
			for Lead Grant- ~~1st~~ 2nd Qtr.			$3889.59
			per attached invoices			
			Less 1st qtr invoice			865.00
						3,024.59
					TOTAL	~~$3889.99~~

STATE OF OKLAHOMA, COUNTY OF Ottawa

The undersigned (architect, contractor, supplier or engineer), of lawful age, being first duly sworn, on oath says that this (invoice, claim or contract) is true and correct. Affiant further states that the (work, services, or materials) as shown by this invoice or claim have been (completed or supplied) in accordance with the plans, specifications, orders or requests furnished the affiant. Affiant further states that (s)he has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly, to any elected official, officer or employee of the State of Oklahoma, of money or any other thing of value to obtain payment or the award of this contract.

Jane Ann Nichols
Architect, Contractor, Supplier or Engineer

Subscribed and sworn to before me this 26th day of February 2001 X19 ___

Janice Lenin
Notary Public (County Clerk or Judge)

My commission expires:
5-27-01

OFFICIAL USE ONLY: X069364 NW97

[redacted]	000135 NW97
PO # or CT #	Account Number
/ / 1002 OK	~~400BT11~~ [redacted]
Complete-Partial	Fund Number
~~[illegible]~~ 42000 OK	5511 A-X
Sub-Activity	Object Code
/ / /	
Math Entered	Claim Number
[illegible]	3-12-01
INV Funded By	Date

APPROVED FOR PAYMENT

[signature] / [signature]
Program Supervisor

Oklahoma State Department of Health
Financial Management Service - 0102
1000 N.E. 10th St.
Oklahoma City, Oklahoma 73117-1299

OKLAHOMA STATE DEPARTMENT OF HEALTH
Financial Management Service

INVOICE

12/91 ODH FORM 8

OTTAWA COUNTY HEALTH DEPARTMENT
OTTAWA

1930 ELM NORTHEAST
MIAMI, OKLAHOMA 74354
PHONE: 918-540-2481

February 27, 2001

TO: Ken Cadaret

FROM: Janice Buck

SUBJECT: Lead Grant Reimbursement

Attached please find form 8 with Invoices attached. We need a code for the LEP Program for the lead grant. Can you work this out for us?

Thanks.

Jan Buck

Is that still the plan as I an getting together a billing—do we need a P>O> NUMBER??

Thank you-Jane Ann nichols

U.S. Cellular

Account Number: 575816438
Bill Date: 11/14/00
Invoice Number: 575816438-009

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 11/14/00	Credits and Adjustments to Prev. Balance	Past Due Balance	Current Charges Due by 12/14/00	TOTAL AMOUNT DUE
46.23	46.23CR	0.00	0.00	40.64	$40.64

ACCOUNT SUMMARY

Previous Balance	46.23	
Payments Received thru 11/14/00. Thank you !	46.23CR	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		0.00
Monthly Service Charges	39.95	
Local Usage	0.00	
Extended Home Service Area Charges	0.00	
Roaming Charges	0.00	
Other Charges & Credits	0.69	
Taxes	0.00	
Total Current Charges Due by 12/14/00		40.64
TOTAL AMOUNT DUE		$40.64 OK

Thank you for choosing our wireless service. We appreciate your business.
For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S. Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on back.

Account Number : 575816438

Total Amount Due by 12/14/00	Amount Enclosed
$40.64	

7561R-10795

U.S. Cellular
P.O. Box 650684
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

75857581643831000004064 69

SOONER

Miami, OK 918-540-2422
Fax 918-542-5751

Grove, OK 918-787-5522
Fax 918-787-5548

Remit To:
P.O. Box 550
Miami, OK 74355

INVOICE 4390

CUSTOMER ACCOUNT NO.

CUSTOMER ORDER NO.

JOB NUMBER

SOLD TO

ADDRESS

☐ UPS ☒ Delivered

☐ Pickup ☐ Non taxable

Date

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
			1495	29 90
1	1			55 50
				13 40
			Disc	12 81
				72 59
		All accounts due and payable in full by the 10th following purchase. A FINANCE CHARGE OF 2% per month with a minimum charge of 50¢ which is a corresponding ANNUAL PERCENTAGE RATE OF 24% will be added to unpaid balance thereafter.		

RECEIVED BY

SOONER

Miami, OK 918-540-2422
Fax 918-542-5751

Grove, OK 918-787-5522
Fax 918-787-5548

Remit To:
P.O. Box 550
Miami, OK 74355

INVOICE 7005

CUSTOMER ACCOUNT NO.

CUSTOMER ORDER NO.

JOB NUMBER

SOLD TO [illegible]

ADDRESS

☐ UPS ☐ Delivered

☐ Pickup ☐ Non taxable

Date [illegible] OK

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
1	1	[illegible]		[illegible]
				[illegible]
				[illegible]
		All accounts due and payable in full by the 10th following purchase. A FINANCE CHARGE OF 2% per month–with a minimum charge of 50¢ which is a corresponding ANNUAL PERCENTAGE RATE OF 24% will be added to unpaid balance thereafter.		

RECEIVED BY

Invoice

R C SALES AD SPECIALTIES asi303321

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

ATTN: JANICE BUCK
I WILL FORWARD ORIGINAL.

DATE	INVOICE #
11/15/00	12753

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
1228	NET 10 DAYS		11/15/00	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
500	NONINVENTORY	BLACK TOTE BAGS IMPRINTED 2 SIDES	3.99	1,995.00T
24	NONINVENTORY	OVERRUN SAME	0.00	0.00T
	UPS		35.00	35.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you!

Thank you for your business.

Total $2,030.00

OK

R C SALES AD SPECIALTIES asi303321

Invoice

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

DATE	INVOICE #
11/17/00	12755

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
958	NET 10 DAYS		11/17/00	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
1,000	NONINVENTORY	YELLOW PENCILS IMPRINTED WITH LOGO	0.15	150.00T
	NONINVENTORY	SET UP	0.00	0.00T
	UPS		0.00	0.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you!

Thank you for your business.

Total $150.00

OK

Invoice

R C SALES AD SPECIALTIES asi303321

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

DATE	INVOICE #
10/2/00	12704

RECEIVED
OCT 4 2000
OTTAWA COUNTY HEALTH DEPT.

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
958	NET 10 DAYS		10/2/00	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
5,000	NONINVENTORY	4-COLOR ROLL LABELS LEAD FREE	0.1172	586.00T
	UPS		12.87	12.87T
		TAX SALES PERMIT	0.00%	0.00

paid

Thank you!

Thank you for your business.

Total ~~$598.87~~ 586.00

Invoice

R C SALES AD SPECIALTIES asi303321

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

RECEIVED
OCT
OTTAWA COUNTY HEALTH DEPT.

DATE	INVOICE #
9/27/00	12714

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
958	NET 10 DAYS		9/27/00	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
500	NONINVENTORY	#267 SIP-A-BABY CUP ASSORTED COLORS -- IMPRINTED LIDS	1.65	825.00T
1	NONINVENTORY	SET UP	40.00	40.00T
	UPS	INCLUDED	0.00	0.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you!

DO NOT PAY

Thank you for your business.

Total $865.00

SOONER

Miami, OK 918-540-2422
Fax 918-542-5751

Grove, OK 918-787-5522
Fax 918-787-5548

Remit To:
P.O. Box 550
Miami, OK 74355

INVOICE 4052

CUSTOMER ACCOUNT NO.

CUSTOMER ORDER NO.

JOB NUMBER

SOLD TO Ottawa Co Health Dept

ADDRESS

☐ UPS ☑ Delivered
☐ Pickup ☑ Non taxable

Date 11-7-00

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
4	pkg	Magazine holders	4.46	17.84
				[illegible]
				15.16
				NT
		All accounts due and payable in full by the 10th following purchase. A FINANCE CHARGE OF 2% per month–with a minimum charge of 50¢ which is a corresponding ANNUAL PERCENTAGE RATE OF 24% will be added to unpaid balance thereafter.		

RECEIVED BY

SOONER

Miami, OK 918-540-2422
Fax 918-542-5751

Grove, OK 918-787-5522
Fax 918-787-5548

Remit To:
P.O. Box 550
Miami, OK 74355

INVOICE 3786

CUSTOMER ACCOUNT NO.

CUSTOMER ORDER NO.

JOB NUMBER

SOLD TO [illegible]

ADDRESS

☐ UPS ☐ Delivered
☐ Pickup ☐ Non taxable

Date [illegible]

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
[illegible]	2	[illegible]	[illegible]	[illegible]
				[illegible]
				[illegible]
		All accounts due and payable in full by the 10th following purchase. A FINANCE CHARGE OF 2% per month–with a minimum charge of 50¢ which is a corresponding ANNUAL PERCENTAGE RATE OF 24% will be added to unpaid balance thereafter.		

RECEIVED BY [illegible]

SOONER

Miami, OK 918-540-2422
Fax 918-542-5751

Grove, OK 918-787-5522
Fax 918-787-5548

Remit To:
P.O. Box 550
Miami, OK 74355

INVOICE 3786

CUSTOMER ACCOUNT NO.

CUSTOMER ORDER NO.

JOB NUMBER

SOLD TO [illegible]

ADDRESS

☒ UPS ☐ Delivered
☐ Pickup ☐ Non taxable

Date 10-31-00

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
1	[illegible]	[illegible]		16 00
		122734936237		
		All accounts due and payable in full by the 10th following purchase. A FINANCE CHARGE OF 2% per month–with a minimum charge of 50¢ which is a corresponding ANNUAL PERCENTAGE RATE OF 24% will be added to unpaid balance thereafter.		

RECEIVED BY [illegible]

U.S. Cellular

Account Number: 575816438
Bill Date: 10/14/00
Invoice Number: 575816438-008

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 10/14/00	Credits and Adjustments to Prev. Balance	Past Due Balance	Current Charges Due by 11/13/00	TOTAL AMOUNT DUE
43.44	43.44CR	0.00	0.00	46.23	$46.23

ACCOUNT SUMMARY

Previous Balance	43.44	
Payments Received thru 10/14/00. Thank you !	43.44CR	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		0.00
Monthly Service Charges	39.95	
Local Usage	4.72	
Extended Home Service Area Charges	0.00	
Roaming Charges	0.87	
Other Charges & Credits	0.69	
Taxes	0.00	
Total Current Charges Due by 11/13/00		46.23
TOTAL AMOUNT DUE		$46.23

Thank you for choosing our wireless service. We appreciate your business.
For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S. Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on back.

7581R-10820

Account Number : 575816438

Total Amount Due by 11/13/00	Amount Enclosed
$46.23	

U.S. Cellular
P.O. Box 650684
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

75857581643831000000462359

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	135529

FOR AGENCY USE
WARRANT # 8109682 DATE: 06/05/2001

ACCOUNT	SUB ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	000000000	3,084.84

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 3,084.84

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee
Date: _____
Claimant: _____

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
006		3,084.84

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010430

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
05/01/2001	042001	3,084.84

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 3084.84

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

06/01/2001

Title Date

Agency, Bd or Div. Use

135529 Pd

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

INVOICE

Bill To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299

Remit To:
PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 5/1/01

Billing Period: 4/1/01 through 4/30/01

Purchase Order #: X041428

CONTRACTOR Representative:

Bob Walker, Superintendent

918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	136	Hour	Teachers Aides - reading and math activities and assistance	8.00	1088.00
002	136	Hour	Teachers Aides - speech language remediation	8.00	1088.00
003	64	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	512.00
004	2	Monthly	Fringe Benefits (Health Insurance)	198.42	396.84
				Total Amount	$3,084.84

X041428 PURCHASE DOCUMENT
000135NW77 ACCOUNT NO.
COMPLETE
PARTIAL
FUND NO.
SUB ACTIVITY
OBJECT CODE
MATH
ENTERED
CLAIM NUMBER
05-21-2001
DATE

Total number of students served during the billing period: 250

5/10/01

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
4-2-01	4	4		8
4-3-01	4	4		8
4-4-01	4	4		8
4-5-01	4	4		8
4-6-01			8	8
4-9-01	4	4		8
4-10-01	4	4		8
4-11-01	4	4		8
4-12-01			8	8
4-13-01	4	4		8
4-16-01	4	4		8
4-17-01	4	4		8
4-18-01	4	4		8
4-19-01			8	8
4-20-01	4	4		8
4-23-01	4	4		8
4-24-01	4	4		8
4-25-01	4	4		8
4-26-01	4	4		8
4-27-01			8	8
4-30-01	4	4		8

Total Time Sheet Hours	168

Employee signature: Joann Roberts **Date:** 4-30-01

Supervisor signature: Kimberly D. Pace **Date:** 4-30-01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Myca K. Morton

Date	001 Hours	002 Hours	003 Hours	Total hours
4-02-01	4	4		8
4-03-01	4	4		8
4-04-01	4	4		8
4-05-01	4	4		8
4-06-01			8	8
4-09-01	4	4		8
4-10-01	4	4		8
4-11-01	4	4		8
4-12-01			8	8
4-13-01	4	4		8
4-16-01	4	4		8
4-17-01	4	4		8
4-18-01	4	4		8
4-19-01			8	8
4-20-01	4	4		8
~~4-24-01~~ 4-23-01	4	4		8
4-24-01	4	4		8
4-25-01	4	4		8
4-26-01	4	4		8
4-27-01			8	8
4-30-01	4	4		8

Total Time Sheet Hours	168

Employee signature: Myca K Morton **Date:** 4-30-01

Supervisor signature: Kimberly D. Pace **Date:** 4/30/01

Farmer, Pat A.

From: Farmer, Pat A.
Sent: Monday, May 21, 2001 10:20 AM
To: Fouquet, Sonja F.
Subject: Amount Over Order(X041428)

Sonja, I have an invoice for payment to Picher-Cardin Public Schools in the amount of $3,084.84 for the month of April, 2001 that will not go into the system because of the amount being over order. The budget period ends June, 2001, so payments for May and June will still be pending. Please advise. This invoice is funded on 400BT11/000135NW97/42000. Thanks

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	138186

FOR AGENCY USE
WARRANT # 8191385 DATE: 06/26/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	937780000	3,340.84

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 3,340.84

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	3,340.84
007		DISTRIBUTED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010531

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
06/01/2001	05	3,340.84

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 3340.84

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

06/22/2001

Title Date

Agency, Bd or Div. Use

138186 pg

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

RECEIVED
JUN 04 2001
OTTAWA COUNTY HEALTH DEPT

INVOICE

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 6-1-01

Billing Period: 5-1-01 through 5-31-01

Purchase Order #: X041428

CONTRACTOR Representative:

Bob Walker, Superintendent

918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	163	Hour	Teachers Aides - reading and math activities and assistance	8.00	1,304.00
002	163	Hour	Teachers Aides - speech language remediation	8.00	1,304.00
003	42	Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	336.00
			736021187 (05)		
004	2	Monthly	Fringe Benefits (Health Insurance)	198.42	396.84
				Total Amount	$3,340.84

PURCHASE DOCUMENT | ACCOUNT NO.
COMPLETE | PARTIAL | FUND NO.
SUB ACTIVITY | OBJECT CODE
MATH | ENTERED | CLAIM NUMBER
INVOICE APPROVED: 250 | DATE 6-21-01

Total number of students served during this billing period: 250

06-22-2001

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Myca Morton

Date	001 Hours	002 Hours	003 Hours	Total hours
5 01 01	4	4		8
5 02 01	4	4		8
5 03 01	4	4		8
5 04 01	1	0	7	8
5 07 01	4	4		8
5 08 01	4	4		8
5 09 01	4	4		8
5 10 01	4	4		8
5 11 01	0	1	7	8
5 14 01	4	4		8
5 15 01	4	4		8
5 16 01	4	4		8
5 17 01	4	4		8
5 18 01	1/2	1/2	7	8
5 21 01	4	4		8
5 22 01	4	4		8
5 23 01	4	4		8
5 24 01	4	4		8
5 25 01	4	4		8
5 28 01	4	4		8
5 29 01	4	4		8
5 30 01	4	4		8
5 31 01	4	4		8

Total Time Sheet Hours	184

Employee signature: Myca Morton **Date:** 6 01 01

Supervisor signature: Kimberly D. Pace **Date:** 6-01-01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
5-1-01	4	4		8
5-2-01	4	4		8
5-3-01	4	4		8
5-4-01	1		7	8
5-7-01	4	4		8
5-8-01	4	4		8
5-9-01	4	4		8
5-10-01	4	4		8
5-11-01		1	7	8
5-14-01	4	4		8
5-15-01	4	4		8
5-16-01	4	4		8
5-17-01	4	4		8
5-18-01	1/2	1/2	7	8
5-21-01	4	4		8
5-22-01	4	4		8
5-23-01	4	4		8
5-24-01	4	4		8
5-25-01	4	4		8
5-28-01	4	4		8
5-29-01	4	4		8
5-30-01	4	4		8
5-31-01	4	4		8

Total Time Sheet Hours 184

Employee signature: Joann Roberts **Date:** 5-31-01

Supervisor signature: Kimberly D. Pace **Date:** 5-31-01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X041428	209859

FOR AGENCY USE
WARRANT # 7325675 DATE: 10/04/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	000000000	3,084.84

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 3,084.84

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant _____

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	3,084.84
008		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20010630

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
07/01/2001	JULY01	3,084.84

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 5511AAAAAX 3084.84

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

_____
Agency's Approving Officer

10/01/2001

Title Date

Agency, Bd or Div. Use

Picher-Cardin Public Schools
P.O. Box 280
715 West "A" Street
Picher, OK 74360

INVOICE

RECEIVED
JUL 02 2001
OTTAWA COUNTY HEALTH DEPT.

Bill To:	Remit To:
OKLAHOMA STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N. E. 10TH STREET OKLAHOMA CITY, OK 73117-1299	PICHER-CARDIN PUBLIC SCHOOLS P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 7/1/01

Billing Period: 6/1/01 through 6/30/01

Purchase Order #: X041428

CONTRACTOR Representative:

Bob Walker, Superintendent

918-673-1714 ext. 402

Item	Quantity	Unit	Description	Unit Price	Amount
001	168	Hour	Teachers Aides - reading and math activities and assistance	8.00	1,344.00
002	168	Hour	Teachers Aides - speech language remediation	8.00	1,344.00
003		Hour	Teachers Aides - Lead Poisoning Prevention curriculum training	8.00	
	136 024 187				
004	2	Monthly	Fringe Benefits (Health Insurance)	198.42	396.84
				Total Amount	$3,084.84

X041428 PURCHASE DOCUMENT
[illegible] ACCOUNT NO.
COMPLETE PARTIAL
[illegible] FUND NO.
SUB ACTIVITY
[illegible] OBJECT CODE
MATH ENTERED
CLAIM NUMBER
INVOICE APPROVED
9/22/01 DATE

Total number of students covered during this billing period: 50

8/23/01

Copies of Time and Effort sheets that reflect each duty as an acitivity code: Attached

Certified copy of the original on file 7/01/01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Joann Roberts

Date	001 Hours	002 Hours	003 Hours	Total hours
6-1-01	4	4		8
6-4-01	4	4		8
6-5-01	4	4		8
6-6-01	4	4		8
6-7-01	4	4		8
6-8-01	4	4		8
6-11-01	4	4		8
6-12-01	4	4		8
6-13-01	4	4		8
6-14-01	4	4		8
6-15-01	4	4		8
6-18-01	4	4		8
6-19-01	4	4		8
6-20-01	4	4		8
6-21-01	4	4		8
6-22-01	4	4		8
6-25-01	4	4		8
6-26-01	4	4		8
6-27-01	4	4		8
6-28-01	4	4		8
6-29-01	4	4		8

Total Time Sheet Hours	168

Employee signature: Joann Roberts **Date:** 6-29-01

Supervisor signature: Kimberly J. Pace **Date:** 6-29-01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Myca Morton

Date	001 Hours	002 Hours	003 Hours	Total hours
6-1-01	4	4		8
6-4-01	4	4		8
6-5-01	4	4		8
6-06-01	4	4		8
6-07-01	4	4		8
6-08-01	4	4		8
6-11-01	4	4		8
6-12-01	4	4		8
6-13-01	4	4		8
6-14-01	4	4		8
6-15-01	4	4		8
6-18-01	4	4		8
6-19-01	4	4		8
6-20-01	4	4		8
6-21-01	4	4		8
6-22-01	4	4		8
6-25-01	4	4		8
6-26-01	4	4		8
6-27-01	4	4		8
6-28-01	4	4		8
6-29-01	4	4		8

Total Time Sheet Hours	168

Employee signature: Myca Morton **Date:** 6-29-01

Supervisor signature: Kimberly D. Pace **Date:** 6-29-01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CTF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X069364	215680

FOR AGENCY USE
WARRANT # 7505258 DATE: 11/26/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000135	42000	5511	932410000	8,296.68

CLAIM OF:
OTTAWA COUNTY HLTH DEPT (58)
736006404

2 1 5 6 8 0

FOR
$ 8,296.68

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date:

Claimant:

WARRANT LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
003		8,296.68

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
08/27/2001	58LG0801-40	8,296.68

THIS SPACE FOR AGENCY USE

400BT11 000135NW97 551108582X 8296.68

J/E XREF:

VENDOR: OTTAWA COUNTY HLTH DEPT (58)
ADDRESS: 1930 N. ELM
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74354

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/19/2001

Title Date

Agency, Bd or Div. Use

215680

INVOICE NUMBER 581G0801-40

8-27-01, 19
Date Prepared

NAME Ottawa County Health Dept. FID/SSN 73-6006404

Mailing Address (Street/Box Number) 1930 North Elm

City Miami State OK Zip 74354

Service Date MO	DAY	YEAR	Description of Service Rendered	Units Of Svc	Price ($) Per Unit	TOTAL (Unit X $)
08	27	01	Reimburse Ottawa CHD expenses for			
		–	Lead Grant Prevention Program			$11,074.08
			~~(per attached invoices)~~			
		PO#	X069364			
			$2,[illegible] disallowed.			
			$2,487.61 = duplicate expenses			
			included in inv. total			
			$ 289.79 expenses outside p.o.			
			dates - to be pd on IPC			
					Pay	8296.68
			[signature] 11/14/01		TOTAL	~~$11,074.08~~

STATE OF OKLAHOMA, COUNTY OF Ottawa

The undersigned (architect, contractor, supplier or engineer), of lawful age, being first duly sworn, on oath says that this (invoice, claim or contract) is true and correct. Affiant further states that the (work, services, or materials) as shown by this invoice or claim have been (completed or supplied) in accordance with the plans, specifications, orders or requests furnished the affiant. Affiant further states that (s)he has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly, to any elected official, officer or employee of the State of Oklahoma, of money or any other thing of value to obtain payment or the award of this contract.

Jane Ann Nichols by JB
Architect, Contractor, Supplier or Engineer

Subscribed and sworn to before me this 27th day of August 2001, 19

My commission expires: 7-14-04

Tonya Hughes
Notary Public (County Clerk or Judge)

OFFICIAL USE ONLY:

X069364	000135NW97
PO # or CT #	Account Number
/ / 1083 /	400787 11
Complete-Partial	Fund Number
42000	5311 08 [illegible]
Sub-Activity	Object Code
/ / /	
Math Entered	Claim Number
[signature]	11-19-01
INV Funded By	Date

APPROVED FOR PAYMENT

[signature]
Program Supervisor

Oklahoma State Department of Health
Financial Management Service - 0102
1000 N.E. 10th St.
Oklahoma City, Oklahoma 73117-1299

OKLAHOMA STATE DEPARTMENT OF HEALTH
Financial Management Service

INVOICE

12/91 ODH FORM 8

R C SALES AD SPECIALTIES asi303321

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

RECEIVED
MAR 23 2001
OTTAWA COUNTY HEALTH DEPT.

Invoice

DATE	INVOICE #
3/21/01	12867

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	NANCY HORTON LEAD FREE

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
3000	NET 10 DAYS		3/21/01	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
500	NONINVENTORY	SAFETY BLINKER WITH LOGO	1.90	950.00T
	NONINVENTORY	SET UP	0.00	0.00T
	UPS		0.00	0.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you for your business.

Total $950.00

R C SALES AD SPECIALTIES asi303321

Invoice

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

DATE	INVOICE #
3/5/01	12852

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	NANCY HORTON LEAD FREE

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
3000	NET 10 DAYS		3/5/01	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
750	NONINVENTORY	WHITE TELEPHONE NOTE CLIPS IMPRINTED 2 COLOR LOGOS	0.85	637.50T
2	NONINVENTORY	SET UP SCREENS INCLUDED	0.00	0.00T
	UPS	INCLUDED	0.00	0.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you for your business.

Total $637.50

Invoice

R C SALES AD SPECIALTIES asi303321

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

RECEIVED
MAR 13 2001

DATE	INVOICE #
3/11/01	12857

OTTAWA ~~COUNTY HEALTH DEPT~~

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	NANCY HORTON LEAD FREE

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
3000	NET 10 DAYS		3/11/01	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
1,000	NONINVENTORY	YELLOW TRANSLUCENT INK PENS IMPRINTED WITH LOGO	0.50	500.00T
50	NONINVENTORY	SAME OVERRUN NO CHARGE	0.00	0.00T
	UPS	INCLUDED	0.00	0.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you for your business.

Total $500.00

R C SALES AD SPECIALTIES asi30332

Invoice

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

DATE	INVOICE #
2/25/01	12845

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	NANCY HORTON LEAD FREE

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
3000	NET 10 DAYS		2/25/01	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
100	NONINVENTORY	GOLDTONE SWIVEL CLOCK IMPRINTED WITH LOGO	3.99	399.00T
	UPS		0.00	0.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you for your business.

Total $399.00

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WE SELL FOR LESS
MANAGER CHUCK STOTTS
(918) 642 - 1274

ST# 0028 OP# 00000146 TE# 91 TR# 00009

435	007874222852	4.20 H
SHEET PROTCT	007771174086	3.27 H
SHEET PROTCT	007771174086	3.27 H
SHEET PROTCT	007771174086	3.27 H
SHEET PROTCT	007771174086	3.27 H
CARD STOCK	003650009360	4.97 H
NAIL BRUSH	007163101609	
8 AT 1 FOR	1.50	12.00 H
BATTERY	001280046035	4.97 H
GLADWARE	001258761122	2.47 H
PAINT	002899520403	1.67 H
APPLEBRL PNT	002899520430	1.67 H
PAINT	002899520401	1.67 H
APPLEBRL PNT	002899520427	1.67 H
APPLE BARREL	002899520413	1.67 H
APPLEBRL PNT	002899520422	1.67 H
BABY POWDER	030869167810	1.67 H
435	007874222852	4.40 H
435	007874222852	4.40 H
GLADWARE	001258761122	2.47 H
FABRIC	074672447500	12.00 H
12.000 YD	AT 1 YD FOR 1.00	
	SUBTOTAL	76.65
	TOTAL	76.65
	WALMART CREDIT TEND	76.65

ACCOUNT #0101-99/99
APPROVAL #000959
TRANS ID -
VALIDATION -
PAYMENT SERVICE - M

CHANGE DUE 0.00

ITEMS SOLD 27

TC# 3707 5585 5531 9472 9526

SHOP ONLINE ANYTIME AT WALMART.COM
02/01/01 14:50:23

CUSTOMER COPY

U.S. Cellular

Account Number: 575816438
Bill Date: 1/14/01
Invoice Number: 575816438-011

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 1/14/01	Credits and Adjustments to Prev. Balance	Past Due Balance	Current Charges Due by 2/13/01	TOTAL AMOUNT DUE
126.87CR	167.51	0.00	40.64	30.60	$71.24

ACCOUNT SUMMARY

Previous Balance	126.87CR	
Net Payments thru 1/14/01	167.51	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		40.64
Monthly Service Charges	29.95	
Local Usage	0.00	
Extended Home Service Area Charges	0.00	
Roaming Charges	0.00	
Other Charges & Credits	0.65	
Taxes	0.00	
Total Current Charges Due by 2/13/01		30.60
TOTAL AMOUNT DUE		$71.24

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For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S. Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on back.

Account Number: 575816438

Total Amount Due by 2/13/01	Enter Amount Enclosed
$71.24	71.24

75819R-10847

U.S. Cellular
P.O. Box 650684
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

75857581643831000007124 69

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MANAGER CHUCK STOTTS
(918) 542 - 1274

ST# 0028 OP# 00000083 TE# 93 TR# 04697

PAPER	007234801165	1.97 H
PAPER	007234801165	1.97 H
PAPER	007234801165	1.97 H
PAPER	007234801165	1.97 H
EYES	002844452713	2.97 H
EYES	002844452713	2.97 H
EYES	002844452713	2.97 H
LUNCH BAGS	007150720061	1.38 H
LUNCH BAGS	007150720061	1.38 H
GLUE STICK	002600000522	0.98 H
GLUE STICK	002600000522	0.98 H
GLUE STICK	007166211129	0.97 H
GLUE STICK	007166211129	0.97 H
GLUE STICK	007166211129	0.97 H
QUAD PADS	002622978814	3.27 H
QUAD PADS	002622978814	3.27 H
QUAD PADS	002622978814	3.27 H
QUAD PADS	002622978814	3.27 H
BOUNTY 8 RLL	003700063903	6.97 H
GLUE STIC LR	007170900221	0.97 H
GLUE STIC LR	007170900221	0.97 H
GLUE STIC LR	007170900221	0.97 H
BOYS SOCKS	007658607080	3.96 H
BOYS SOCKS	007658607080	3.96 H
BOYS SOCKS	007658607080	3.96 H
PAINT	002899517726	2.47 H
PAINT	002899517726	2.47 H
PAINT	002899517727	2.47 H
PAINT	002899517728	2.47 H
PAINT	002899517728	2.47 H
POSTER PAINT	002899520976	1.97 H
PAINT	002899517727	2.47 H
MAGNIFIER	002402100063	4.38 H
MAGNIFIER	002402100068	4.97 H
POSTER PAINT	002899520976	1.97 H
POSTER PAINT	002899520976	1.97 H
GHOSTLINE BR	007978454480	1.97 H
GHOSTLINE BR	007978454480	1.97 H
GHOSTLINE BR	007978454480	1.97 H
GHOSTLINE BR	007978454480	1.97 H
GHOSTLINE BR	007978454480	1.97 H
GHOSTLINE BR	007978454480	1.97 H
SUBTOTAL		101.16
TOTAL		101.16
WALMART CREDIT TEND		101.16

ACCOUNT #0101-99/99
APPROVAL #000984
TRANS ID -
VALIDATION -
PAYMENT SERVICE - N
CHANGE DUE 0.00

ITEMS SOLD 42

TC# 3496 1109 6170 2365 3913 1

SHOP ONLINE ANYTIME AT WALMART.COM
02/02/01 15:26:33

lead Project

Original since 1968

Accept NO Substitutes!

Glo Germ Company

P.O. BOX 537
MOAB, UTAH 84532
435-259-5931
800-842-6622 USA
613-342-8561 CANADA
435-259-5930 FAX
www.glogerm.com

Invoice

DATE	INVOICE #
01/31/2001	20025

BILL TO:

OTTAWA CO. HEALTH DEPT.
1930 N. ELM
MIAMI OK 74354

SHIP TO:

OTTAWA CO. HEALTH DEPT.
1930 N. ELM
MIAMI OK 74354
ATTN; JANIC

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
2993	Net 30	CH	01/31/2001	UPS	MOAB	

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
	KIT 1002	1002 KIT (UV LIGHT OIL & POWDER		49.95
2	GGP	4 OZ BOTTLE GLO GERM POWDER	12.95	25.90
	ABC TAPE	ABC TAPE WITH GMMS BOOK	15.00	15.00
	GGSLAMM	SILLY SAMMER TOY	7.95	7.95
	DSH	SHIPPING AND HANDLING	8.90	8.90

PLEASE REMIT COPY OF INVOICE WITH PAYMENT

TOTAL $107.70

Kenneth Wagener
1311 Scott Lane
Miami, OK 74354
Telephone: 918-542-5389

- INVOICE -

2/19/01

(1) Puppet Screen Support Set per quote dated 2/1/01	$40.50
8 foot curtain pole	9.00
6 foot curtain pole	7.00
Total	$56.50

Kenneth Wagener

Received 2-20-01 nch

PUPPETS ON THE PIER
5618 Geary Blvd, Ste #106
San Francisco, CA 94121
Tel (415) 781-4435

INVOICE 173
DATE 2/15/01

Bill To:
Ottawa County Health Dept
1930 North Elm Street
Miami OK 74354

Ship To:
Ottawa County Health Dept
1930 North Elm Street
Miami OK 74354

P.O.Number	Terms	
Janice	Net 30	Tel (918) 540-2481

Description	Amount
Butterfly Puppet 2 pcs @ $18.50 each	37.00
Mini Butterfly Puppet Set	18.00
Shipping & Handling	6.00
Subtotal	61.00
Total	$61.00

Amount Paid $0
Amount Due $61.00

HR-4

Health Research, Inc.
One University Place
Rensselaer, New York 12144-3456

VOUCHER

CONTRACTOR

Ottowa County Health Dept.	535-19-8211-02
	HRI Reference Number
1930 North Elm	
	Contract Period
Attn: Reba Sill, County Clerk	Mr. John Cahill
	Project Director
Miami, Oklahoma 74354-7043	22-492360-05
	Contract Number
	#535
	Voucher Number

PO: 332
Reimbursement requested in the amount of $50.00 for one copy of "The Trouble with Lead" video and "The Trouble with Lead" video loop.

Total $50.00

Remit Payment To: Health Research, Inc.
One University Place
Rensselaer, New York 12144-3456

I hereby certify that the above articles were sold and delivered and the above services rendered on the dates and for the prices billed; and that the above bill is just, true, and correct; that no part thereof has been paid except as stated therein and that the balance therein stated is actually due and owing.

7/12/00
Date

Name

Assoc. Dir. of Accounting & Finance
Title

MASTERCRAFT PUPPETS

PO BOX 2002
BRANSON MO 65615-2002

Invoice
Invoice #: 00008626

Bill To:
OTTAWA COUNTY HEALTH DEPT.
1930 N. ELM
MIAMI, OK 74354

Ship To:
OTTAWA COUNTY HEALTH DEPT.
1930 N. ELM
MIAMI, OK 74354

SALESPERSON	YOUR NO.	SHIP VIA	COL	PPD	SHIP DATE	TERMS	DATE	PG.
	TELE PO 3119	UPS			2/13/01	Net 30	2/12/01	1

QTY.	ITEM NO.	DESCRIPTION	PRICE	UNIT	DISC	EXTENDED	TX.
1	TITUS	TITUS TURTLE	$50.00	EA		$50.00	
1	MISCL	TILLY TURTLE	$50.00	EA		$50.00	

THANK YOU! WE HOPE YOU ENJOY YOUR PUPPETS.

SALE	$100.00
FREIGHT	$8.00
SALES TAX	$0.00
TOTAL	$108.00
PAID TODAY	$0.00
BALANCE	$108.00

THE PUPPET FACTORY INC.
117 E. 17TH STREET
GOODLAND, KS 67735

Office (785) 899-7143
Fax (785) 899-2721

Sales Invoice 3292
Date 2/12/01
Customer ID OCHD

Purchase Order ID 3092
Tax Exemption ID

Bill To
Ottowa County Health Dept.
1930 N. Elm
Miami, OK 74354

Ship To
Ottowa County Health Dept.
1930 N. Elm
Miami, OK 74354

Quantity	Description	Discount	Unit Price	Item Total
1.00	SP2031 - HONEY BEE	0.00%	$25.00	$25.00

THANK YOU FOR YOUR ORDER

PLEASE PAY FROM THIS INVOICE.

DUE DATE 3/14/01
AFTER DUE DATE $42.00

Shipping Method UPS
Salesperson No Salesperson
Payment Terms Net 30 Days
Payment Method No Payment Received

Subtotal	$25.00
Discount 0.00%	$0.00
Sales Tax	$0.00
Ship & Packing Total	$7.00
Total	$32.00
Amount Paid	$0.00
Balance Due	$32.00

U.S. Cellular

Account Number: 575816438
Bill Date: 2/14/01
Invoice Number: 575816438-012

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 2/14/01	Credits and Adjustments to Prev Balance	Past Due Balance	Current Charges Due by 3/16/01	TOTAL AMOUNT DUE
71.24	71.24CR	0.00	0.00	30.60	$30.60

ACCOUNT SUMMARY

Previous Balance	71.24	
Payments Received thru 2/14/01. Thank you !	71.24CR	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		0.00
Monthly Service Charges	29.95	
Local Usage	0.00	
Extended Home Service Area Charges	0.00	
Roaming Charges	0.00	
Other Charges & Credits	0.65	
Taxes	0.00	
Total Current Charges Due by 3/16/01		30.60
TOTAL AMOUNT DUE		$30.60

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For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S. Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on back.

Account Number : 575816438

Total Amount Due by 3/16/01	Amount Enclosed
$30.60	

7581R-11804

U.S. Cellular
P.O. Box 650684
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

7585758164383100000306019

IKON Office Solutions

SHIP TO INVOICE Page # 1

IKON Customer Service Center
Call Toll Free 1-877-783-4566

SHIPPED TO

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

INVOICE INFORMATION

Customer #	J7A526	Dist. Code	00
Date	03/01/01	Order Date	03/01/01
Invoice #	44451A	Ship Date	03/01/01
PO Number	JANICE BUCK	Shipped VIA	UPS GROUND

ATTN:

BILLING INFORMATION

AKA # J7A526
DEPT OF HEALTH
1000 NE 10TH ST

OKLAHOMA CITY, OK 73117-1207001

				RC306 H0100100116		
2	CTG	2	MCROP	RIC TONER TYPE K1-BLACK (4CTG/CTN)3006,4006,4106 Ref # 887914	38.800	77.60
1	CTG	1	MCROR	RIC TONER TYPE K1-MAGENTA (4CTG/CTN)3006,4006,4106 Ref # 887927	125.000	125.00

ORDERED BY JANICE BUCK
918-540-2481
THANK-YOU

230334400

Lead will pay 1 Black 38.80 from Tickets

PO # or CT #	Account Number
Complete - Partial	Fund Number
Sub-Activity	Object Code

SUBTOTAL 202.60
TOTAL DUE 202.60

REC

3-14-01;11:22AM;OSDH ADMIN SERVICES ;405 271 1788 ; # 1/

...CE NO 200548

Ottawa County Health Dept, LPPP
Susan Waldron
1930 N. Elm
Miami OK 74354

RECEIVED
FEB 05
OTTAWA COUNTY HEALTH DEPT

Remit to: LifeLines
PO Box 3547
Mooresville, NC 28117
704-660-7098

Date 1/29/2001

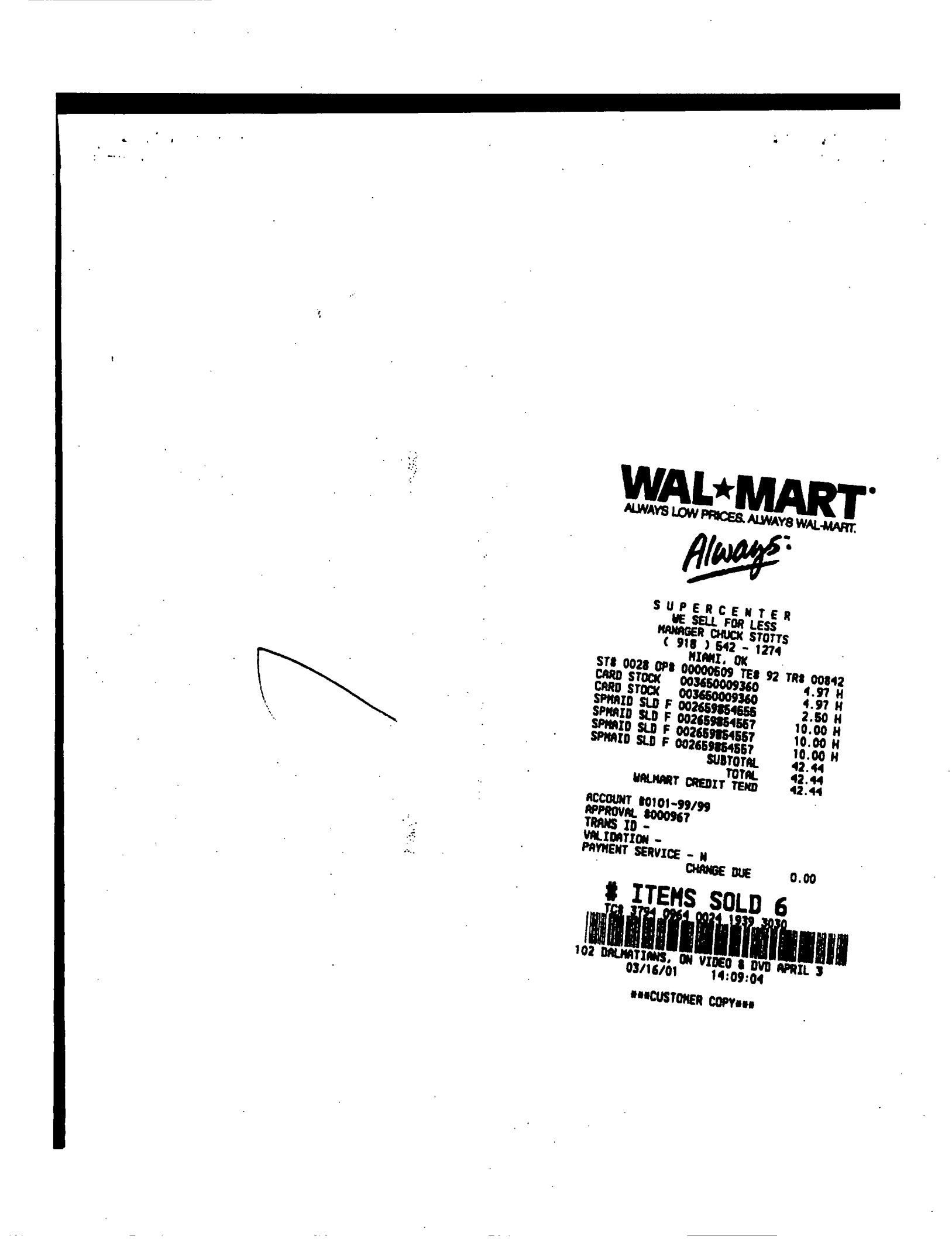
Order Date	Customer ID	Your Ref	Ordered By	Terms	Shipped Via	Rep
1/29/2001	918-540-2481		Susan	Net 30	Overnite	

NO	QTY	UNIT	CODE	DESCRIPTION	UNIT PRICE	EXTENSION
1	6	cs		Parent's Guide Books		
2	3	ea		Displays for Books		
3	4	cs		English Brochures		
4	2	cs		Spanish Brochures		
5	4	ea		Bilingual Displays for Brochures		
				FREIGHT CHARGES ONLY		

SHIPPED TO Date Shipped: 1/29/2001
Ottawa County Health Dept. LPPP Store No.
Susan Waldron
1930 N. Elm
Miami OK 74354

PLEASE NOTE NEW REMIT TO ADDRESS!!!!!!!!!!!!!!!!!!!!

Subtotal	
Tax	
Shipping	167.20
Total	$167.20



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WE SELL FOR LESS
MANAGER CHUCK STOTTS
(918) 542 - 1274
MIAMI, OK

ST# 0028 OP# 00000609 TE# 92 TR# 00842

CARD STOCK	003650009360	4.97 H
CARD STOCK	003650009360	4.97 H
SPMAID SLD F	002659854656	2.50 H
SPMAID SLD F	002659854567	10.00 H
SPMAID SLD F	002659854567	10.00 H
SPMAID SLD F	002659854567	10.00 H
SUBTOTAL		42.44
TOTAL		42.44
WALMART CREDIT TEND		42.44

ACCOUNT #0101-99/99
APPROVAL #000967
TRANS ID -
VALIDATION -
PAYMENT SERVICE - M

CHANGE DUE 0.00

ITEMS SOLD 6

TC# 3794 0964 0024 1939 3030

102 DALMATIANS, ON VIDEO & DVD APRIL 3
03/16/01 14:09:04

CUSTOMER COPY

SOONER

Miami, OK 918-540-2422
Fax 918-542-5751

Grove, OK 918-787-5522
Fax 918-787-5548

Remit To:
P.O. Box 550
Miami, OK 74355

INVOICE 8488

OT120
CUSTOMER ACCOUNT NO.

CUSTOMER ORDER NO.

JOB NUMBER

SOLD TO Ottawa Co Health Dept

ADDRESS

☐ UPS ☒ Delivered

☐ Pickup ☐ Non taxabl

Date 3 7 01

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
6	6	Project Boards RIV-04470	4.95	29 70
			Disc	14 4
				25 2
		All accounts due and payable in full by the 10th following purchase. A FINANCE CHARGE OF 2% per month–with a minimum charge of 50¢ which is a corresponding ANNUAL PERCENTAGE RATE OF 24% will be added to unpaid balance thereafter.		

RECEIVED BY

U.S. Cellular

Account Number: 575816438
Bill Date: 3/14/01
Invoice Number: 575816438-013

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 3/14/01	Credits and Adjustments to Prev. Balance	Past Due Balance	Current Charges Due by 4/13/01	TOTAL AMOUNT DUE
30.60	0.00	0.00	30.60	33.00	$63.60

ACCOUNT SUMMARY

Previous Balance	30.60	
Payments Received thru 3/14/01	0.00	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		30.60
Monthly Service Charges	29.95	
Local Usage	0.00	
Extended Home Service Area Charges	2.59	
Roaming Charges	0.00	
Other Charges & Credits	0.46	
Taxes	0.00	
Total Current Charges Due by 4/13/01		33.00
TOTAL AMOUNT DUE		$63.60

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For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S. Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on Back.

7881R-11622

Account Number : 575816438

Total Amount Due by 4/13/01	Amount Enclosed
$63.60	

U.S. Cellular
P.O. Box 650684
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

75857581643831000000636059

Kenneth Wagener
1311 Scott Lane
Miami, OK 74354
Telephone: 918-542-5389

3/15/01

- QUOTATION -

(2) Puppet Screen Support Sets.....$40.50 ea.....$81.00 Total

Curtain Poles
Four 8 foot long poles.....$ 9.00 ea.....$36.00 Total

Amount of order.....$117.00 Total

Kenneth Wagener

WAL★MART

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Always.

SUPERCENTER
WE SELL FOR LESS
MANAGER CHUCK STOTTS
(918) 542 - 6654
MIAMI, OK

ST# 0028 OP# 00001392 TE# 15 TR# 01290

PLAYFOOD	061423902394	9.86 H
EYELASHES	007846224510	2.64 H
FOAMIES	008267615967	0.33 H
FOAMIES	008267615967	0.33 H
FOAMIES	008267615967	0.33 H
4AA 2-WAY	003980002637	7.96 H
DOWEL ROD	004142602710	0.33 H
	SUBTOTAL	21.78
	TOTAL	21.78
	WALMART CREDIT TEND	21.78

ACCOUNT #0101-99/99
APPROVAL #000967
TRANS ID -
VALIDATION -
PAYMENT SERVICE - N
CHANGE DUE 0.00

ITEMS SOLD 7

TC# 7304 2230 1141 4367 010

102 DALMATIANS, ON VIDEO & DVD APRIL 3
04/05/01 10:01:57

###CUSTOMER COPY###

April 16, 2001

TO; OTTAWA COUNTY HEALTH DEPARTMENT
1930 NORTH ELM
MIAMI, OK 74354

FROM: RYAN SLAUGHTER
PO BOX 452054
GROVE, OK 74345
SS# 494-74-3793

ASSEMBLE BOOK CASES AND INSTALL DOORS.

TOTAL DUE $400.00

Office DEPOT

ORIGINAL INVOICE

FEDERAL ID: 59-2663954

INVOICE/ORDER NUMBER	AMOUNT DUE	PAGE NUMBER
121876987-001	684.41	1 OF 1
INVOICE DATE	TERMS	PAYMENT DUE
02/26/2001	NET 30 DAYS	03/28/2001

SHIP TO:

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

BILL TO:

ATTN: ACCTS PAYABLE
OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

REMIT-TO: OFFICE DEPOT, INC
FILE #81801
LOS ANGELES CA 90074-1801

ACCOUNT NUMBER	ACCOUNT MANAGER	SHIP TO ID	ORDER NUMBER	ORDER DATE	SHIPPED DATE
31604872	HIGGINS, WILLIE	1930NELMST	121876987-001	02/12/2001	02/20/2001
PURCHASE ORDER	RELEASE	ORDERED BY	DELIVERED TO		DEPARTMENT
		JANICE BUCK			

LINE	DEPOT ITEM # /MANUF CODE	ITEM DESCRIPTION /CUSTOMER ITEM #	TAX	U/M	QTY ORD	QTY SHP	B/O	UNIT PRICE	EXTENDED PRICE
01	000972166 JNB-005 NAT	BOOKCASE,84X30,NAT CHERRY	Y	EA	04	04	00	161.490	645.96

SUB-TOTAL 645.96

SALES TAX [illegible]
TOTAL [illegible]

ORDER ORIGIN: PHONE ORDER

** PLEASE REFERENCE ACCOUNT NUMBER AND INVOICE/ORDER NUMBER WITH REMITTANCE **

Office DEPOT

ORIGINAL INVOICE

FEDERAL ID: 59-2663954

INVOICE/ORDER NUMBER	AMOUNT DUE	PAGE NUMBER
122038972-001	806.73	1 OF 1
INVOICE DATE	TERMS	PAYMENT DUE
02/26/2001	NET 30 DAYS	03/28/2001

SHIP TO:

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

BILL TO:

ATTN: ACCTS PAYABLE
OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

REMIT-TO: OFFICE DEPOT, INC
FILE #81801
LOS ANGELES CA 90074-1901

ACCOUNT NUMBER	ACCOUNT MANAGER	SHIP TO ID	ORDER NUMBER	ORDER DATE	SHIPPED DATE
31604872	HIGGINS, WILLIE	1930NELMST	122038972-001	02/13/2001	02/20/2001
PURCHASE ORDER	RELEASE	ORDERED BY	DELIVERED TO		DEPARTMENT
		JANICE BUCK			

LINE	DEPOT ITEM # /MANUF CODE	ITEM DESCRIPTION /CUSTOMER ITEM #	TAX	U/M	QTY ORD	QTY SHP	B/O	UNIT PRICE	EXTENDED PRICE
01	000176024 JN8-033G NAT	DOOR,WOOD-FRAME,GLASS,NAT	Y	EA	02	02	00	104.490	208.98
02	000461574 JN8-092	BOOKCASE,CORNR,OUTSIDE,NA	Y	EA	03	03	01	180.490	541.47

** PARTIAL SHIPMENT - BALANCE OF ORDER WILL BE DELIVERED SEPARATELY **

SUB-TOTAL	750.45
SALES TAX	56.28
TOTAL	806.73

ORDER ORIGIN: FAX ORDER

** PLEASE REFERENCE ACCOUNT NUMBER AND INVOICE/ORDER NUMBER WITH REMITTANCE **

ORIGINAL INVOICE

Office DEPOT

FEDERAL ID: 59-2663954

INVOICE/ORDER NUMBER	AMOUNT DUE	PAGE NUMBER
122038972-002	184.02	1 OF 1
INVOICE DATE	TERMS	PAYMENT DUE
03/19/2001	NET 30 DAYS	04/18/2001

SHIP TO:

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

BILL TO:

ATTN: ACCTS PAYABLE
OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

REMIT-TO: OFFICE DEPOT, INC
FILE #81901
LOS ANGELES CA 90074-1901

ACCOUNT NUMBER	ACCOUNT MANAGER	SHIP TO ID	ORDER NUMBER	ORDER DATE	SHIPPED DATE
31604872	HIGGINS, WILLIE	1930NELMST	122038972-002	02/13/2001	03/13/2001
PURCHASE ORDER	RELEASE	ORDERED BY	DELIVERED TO		DEPARTMENT
		JANICE BUCK			

LINE	DEPOT ITEM # /MANUF CODE	ITEM DESCRIPTION /CUSTOMER ITEM #	TAX	U/M	QTY ORD	QTY SHP	B/O	UNIT PRICE	EXTENDED PRICE
02	000461574 JN8-092	BOOKCASE,CORNR,OUTSIDE,NA	Y	EA	01	01	00	180.490	180.49

SUB-TOTAL	180.49
SALES TAX	13.53
TOTAL	184.02

ORDER ORIGIN: FAX ORDER

ALL AMOUNTS ARE BASED ON U.S. CURRENCY

** PLEASE REFERENCE ACCOUNT NUMBER AND INVOICE/ORDER NUMBER WITH REMITTANCE **

Office DEPOT

FEDERAL ID: 59-2663954

ORIGINAL INVOICE

INVOICE/ORDER NUMBER	AMOUNT DUE	PAGE NUMBER
125113544-001	902.45	1 OF 1
INVOICE DATE	TERMS	PAYMENT DUE
04/02/2001	NET 30 DAYS	05/02/2001

SHIP TO:

OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

BILL TO:

ATTN: ACCTS PAYABLE
OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

REMIT-TO: OFFICE DEPOT, INC
FILE #81801
LOS ANGELES CA 90074-1801

ACCOUNT NUMBER	ACCOUNT MANAGER	SHIP TO ID	ORDER NUMBER	ORDER DATE	SHIPPED DATE
31604872	HIGGINS, WILLIE	1930NELMST	125113544-001	03/20/2001	03/27/2001
PURCHASE ORDER	RELEASE	ORDERED BY	DELIVERED TO		DEPARTMENT
		JANICE BUCK			

LINE	DEPOT ITEM # /MANUF CODE	ITEM DESCRIPTION /CUSTOMER ITEM #	TAX	U/M	QTY ORD	QTY SHP	B/O	UNIT PRICE	EXTENDED PRICE
01	~~000972186~~ JN8-005 NAT	BOOKCASE,84X30,NAT CHERRY	Y	EA	01	01	00	~~161.490~~	~~161.49~~
02	000461533 JN8-090	BOOKCASE,CORNER,INSIDE,NA	Y	EA	02	02	00	265.990	531.98
03	000972505 JN8-033 NAT	DOORS,PAIR,NAT CHERRY	Y	EA	02	02	00	104.490	208.98

RM
740.96

SUB-TOTAL ~~902.45~~

ORDER ORIGIN: PHONE ORDER

SALES TAX
TOTAL ~~902.45~~
ALL AMOUNTS ARE BASED ON U.S. CURRENCY

** PLEASE REFERENCE ACCOUNT NUMBER AND INVOICE/ORDER NUMBER WITH REMITTANCE **

QUILL CORPORATION

P.O. BOX 94081 PALATINE, IL 60094-4081
CUSTOMER SERVICE 1-800-789-8965
SEE REVERSE FOR LOCATION INFORMATION
TIN 36-2952904

INVOICE

ACCOUNT NO.	INVOICE NO.	INVOICE DATE
01009707	4761352	04/02/01

17052 TERMS-NET 30 4

SOLD TO
OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354-5400

SHIP TO
OTTAWA COUNTY HEALTH DEPT
1930 N ELM ST
MIAMI OK 74354

C	Y	CUSTOMER ORDER NO.	QUILL ORDER NO.	DATE ORDERED	DATE SHIPPED	CTNS	WEIGHT	SHIPPED VIA
1	N	BUCKJANICE	5777762	04/02/01	04/02/01	5	116	UPS-DAL/MESQTE

STOCK NUMBER	DESCRIPTION	COLOR	F/P	QUANTITY SHIPPED	UNIT	PRICE	EXTENSION
033 7-222-BK	2" ROUND-RING VIEW BINDER	BLACK	P	48.0EA		3.780	181.44
. ITEM # 7222BK IS THE SAME AS 722201							
033 7-IS-8B	INDEX SYSTEM,8-TAB BULK PACK	WHITE	P	2.0BX		75.980	151.96
033 19125-23	PC PRINTABLE REPORT COVERS	DKBE	P	5.0PK		12.690	63.45
033 WND810	EURO HEATER 1500-WATT	GRAY					
. *THE ITEM ABOVE WILL BE SHIPPED AND BILLED	SEPARATELY*						
004 QL232	MRS FIELDS COOKIE TIN		P	1.0EA	*	*NO CHARGE*	*
. Enjoy your free cookies!	Thank you for your order						
999 SAMDUFFLE	SAMSONITE DUFFLE BAG		P	1.0EA	*	*NO CHARGE*	*
. Thank you for your order!							

**CHECK OUT YOUR QUILL SALE FLYER FOR THE LOWEST PRICE *
**IN AMERICA SALE ON BINDERS! *
**IT'S OUR JOB TO MAKE YOUR JOB EASIER AT QUILL.COM. *

MDSE TOTAL	TAX	SMALL ORD PROC CHG	FREIGHT	INVOICE TOTAL	PAYMENTS APPLIED	CREDITS APPLIED	PLEASE PAY THIS AMOUNT	AMOUNT DU
396.85			FREE	396.85				$396.

AN EXPLANATION OF OUR RETURN, PRICING & FREIGHT POLICIES IS ON THE BACK OF THIS INVOICE. IF YOU HAVE QUESTIONS ABOUT YOUR ORDER OR THIS INVOICE, PLEASE WRITE O

QUILL CORPORATION
P.O. BOX 94081
PALATINE, IL 60094-4081

SOLD TO	ACCOUNT NO.	INVOICE NO.	INVOICE DATE	AMOUNT DU
OTTAWA COUNTY HEALTH DEPT	01009707	4761352	04/02/01	$396.

☐ VISA ☐ AMEX
☐ MASTER CARD
CREDIT CARD # Exp. mo/yr 4

THE AREA BELOW AND THE REVERSE SIDE OF THIS ADVICE ARE PROVIDED FOR YOUR COMMENTS, SUGGESTIONS AND/OR QUILL CATALOG

RETURN THIS PORTION WITH YOUR PAYMENT - DO NOT STAPLE

PLACE AN "X" BELOW ☐ TO ENSURE THESE COMMENTS ARE FORWARDED TO THE ATTENTION OF THE APPROPRIATE QUILL SERVICE REPRESENTATIVE.

00000000000476135200010097074100000039685 4

...STAPLE OR PAPER CLIP

U.S. Cellular

Account Number: 575816438
Bill Date: 4/14/01
Invoice Number: 575816438-014

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 4/14/01	Credits and Adjustments to Prev. Balance	Past Due Balance	Current Charges Due by 5/14/01	TOTAL AMOUNT DUE
63.60	63.60CR	0.00	0.00	30.60	$30.60

ACCOUNT SUMMARY

Previous Balance	63.60	
Payments Received thru 4/14/01. Thank you !	63.60CR	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		0.00
Monthly Service Charges	29.95	
Local Usage	0.00	
Extended Home Service Area Charges	0.00	
Roaming Charges	0.00	
Other Charges & Credits	0.65	
Taxes	0.00	
Total Current Charges Due by 5/14/01		30.60
TOTAL AMOUNT DUE		$30.60

Thank you for choosing our wireless service. We appreciate your business.
For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S. Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on back.

7581R-10668

Account Number : 575816438

Total Amount Due by 5/14/01	Amount Enclosed
$30.60	

U.S. Cellular
P.O. Box 650884
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

7585758164383100000306019

U.S. Cellular

Account Number: 575816438
Bill Date: 5/14/01
Invoice Number: 575816438-015

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 5/14/01	Credits and Adjustments to Prev. Balance	Past Due Balance	Current Charges Due by 6/13/01	TOTAL AMOUNT DUE
30.60	30.60CR	0.00	0.00	129.47	$129.47

ACCOUNT SUMMARY

Previous Balance	30.60	
Payments Received thru 5/14/01. Thank you !	30.60CR	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		0.00
Monthly Service Charges	76.87	
Local Usage	23.10	
Extended Home Service Area Charges	3.20	
Roaming Charges	0.00	
Other Charges & Credits	26.30	
Taxes	0.00	
Total Current Charges Due by 6/13/01		129.47
TOTAL AMOUNT DUE		$129.47

Thank you for choosing our wireless service. We appreciate your business.
For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S. Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on back.

Account Number : 575816438

Total Amount Due by 6/13/01	Amount Enclosed
$129.47	

7561R-10000

U.S. Cellular
P.O. Box 650684
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

7585758164383100001294779

WAL★MART
ALWAYS LOW PRICES. ALWAYS WAL-MART.

Always

S U P E R C E N T E R
WE SELL FOR LESS
MANAGER CHUCK STOTTS
(918) 542 - 6654
MIAMI, OK

ST# 0028 OP# 00001422 TE# 01 TR# 00377

BATTERY	004133303486	4.97 H
NOPKT TEE L	007603122282	3.94 H
SS SLD WSHD	076789818029	6.88 H
SS SLD WSHD	076789818029	6.88 H
SS SLD WSHD	076789818021	6.88 H
NO PKT TEE	007603176294	3.94 H
BATTERY	004133303486	4.97 H
MINI LITE	007068673025	6.97 H
MINI LITE	007068673025	6.97 H
PLATE STAND	007328707317	1.50 H
PLATE STAND	007328707317	1.50 H
PLATE STAND	007328707317	1.50 H
PLATE STAND	007328707317	1.50 H
TRANSFERS	007278203275	12.97 H
	SUBTOTAL	71.37
	TOTAL	71.37
	WALMART CREDIT TEND	71.37

ACCOUNT #0101-99/99
APPROVAL #001042
TRANS ID -
VALIDATION -
PAYMENT SERVICE - N
CHANGE DUE 0.00

ITEMS SOLD 14

TC# 6164 0635 100

DISNEY'S EMPEROR'S
AVAILABLE M
05/01/01

***CUSTOMER (

For lead Project

(Su

WAL★MART
ALWAYS LOW PRICES. ALWAYS WAL-MART.

Always

S U P E R C E N T E R
WE SELL FOR LESS
MANAGER CHUCK STOTTS
(918) 542 - 6654
MIAMI, OK

ST# 0028 OP# 00001151 TE# 05 TR# 03412

TRANSFERS	007278203275	12.97 H
SS SLD WSHD	076789818020	6.88 H
SS SLD WSHD	076789818019	6.88 H
SS SLD WSHD	076789818021	6.88 H
SS SLD WSHD	076789818021	6.88 H
SS SLD WSHD	076789818021	6.88 H
	SUBTOTAL	47.37
	TOTAL	47.37
	WALMART CREDIT TEND	47.37

ACCOUNT #0101-99/99
APPROVAL #001019
TRANS ID -
VALIDATION -
PAYMENT SERVICE - N
CHANGE DUE 0.00

ITEMS SOLD 6

[illegible] 5297 6323

'S NEW GROOVE
AY 1ST
16:23:40

COPY***

U.S.Cellular

Account Number: 575816438
Bill Date: 6/14/01
Invoice Number: 575816438-016

OTTAWA COUNTY HEALTH DEPT

Previous Balance	Payments Received thru 6/14/01	Credits and Adjustments to Prev. Balance	Past Due Balance	Current Charges Due by 7/14/01	TOTAL AMOUNT DUE
129.47	129.47CR	0.00	0.00	61.18	$61.18

ACCOUNT SUMMARY

Previous Balance	129.47	
Payments Received thru 6/14/01. Thank you !	129.47CR	
Credits and Adjustments to Previous Balance	0.00	
Past Due Balance		0.00
Monthly Service Charges	59.90	
Local Usage	0.00	
Extended Home Service Area Charges	0.00	
Roaming Charges	0.00	
Other Charges & Credits	1.28	
Taxes	0.00	
Total Current Charges Due by 7/14/01		61.18
TOTAL AMOUNT DUE		$61.18

Thank you for choosing our wireless service. We appreciate your business.
For all billing inquiries, call 888-944-9400 or call 611 or *611 from your cellular phone.

Please detach and mail bottom portion with your payment to ensure prompt handling.

U.S.Cellular

U.S. Cellular
4700 S. Garnett Rd
Tulsa, OK 74146-5299

☐ Check box to indicate address change and/or comments on back.

7581R-10857

Account Number : 575816438

Total Amount Due by 7/14/01	Amount Enclosed
$61.18	

U.S. Cellular
P.O. Box 650684
Dallas TX 75265-0684

OTTAWA COUNTY HEALTH DEPT
1930 ELM NE
MIAMI OK 74354

7585758164383100000611849

Invoice

R C SALES AD SPECIALTIES asi303321

ROBERT C. "BOB" SMITH
730 19th N W AVE.
MIAMI, OK. 74354
PH/FAX 918/542-8850

RECEIVED
JUN 15 2001
OTTAWA COUNTY HEALTH DEPT.

DATE	INVOICE #
6/14/01	12997

BILL TO	SHIP TO
OTTAWA COUNTY HEALTH DEPT. 1930 N. ELM MIAMI,OK. 74354 540-2481 FAX 540-2486	NANCY HORTON LEAD FREE

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
3901	NET 10 DAYS		6/14/01	UPS		

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
500	NONINVENTORY	NECK TOTE ASSORTED COLORS IMPRINTED WITH LOGO	0.82	410.00T
1	NONINVENTORY	SET UP	40.00	40.00T
	UPS		21.00	21.00T
		TAX SALES PERMIT	0.00%	0.00

Thank you.

Thank you for your business.

Total $471.00

06/29/01 08:52 FAX 1 918 542 6885 ALLEN SIGN 001

Allen Sign

S · T · U · D · I · O

307 East Central
Miami, Oklahoma 74354
918-542-1180

INVOICE 6825

PO NO. 4316

DATE 5-19-01

SOLD TO Ottawa County Health Dept. CONTACT Susan Weldon PHONE NUMBER

STREET OR P.O. BOX CITY STATE ZIP

QUANTITY	DESCRIPTION	UNIT PRICE	AMOUNT
2	6'X12' Billboard Faces, Unstalled		432 —

TERMS: DUE UPON RECEIPT

SERVICE CHARGES WILL APPLY IF PAYMENT IS NOT RECEIVED WITHIN 10 DAYS OF THE INVOICE DATE.

Major Credit Cards Welcome *Financing Available*

RECEIVED BY _____

SUB TOTAL	
FREIGHT	
TAX	
JOB TOTAL	
LESS DEPOSIT	
BALANCE	432 —

Papazuo's Pizza
20 Goodrich Blvd
Miami, Ok. 74354

197543

CUSTOMER'S ORDER NO.	DEPARTMENT	DATE 6-26-01

NAME Ottawa County Health Coalition

ADDRESS

CITY, STATE, ZIP

SOLD BY	~~CASH~~ 4774	C.O.D.	CHARGE	ON ACCT.	MDSE RETD	PAID OUT

QUANTITY	DESCRIPTION	PRICE	AMOUNT
1			
2	Meeting Room Charge		$100.00
3			
4			
5			
6			
7			
8			
9	Total		$100.00
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

RECEIVED BY Nancy Horton RN

Adams
5805

KEEP THIS SLIP FOR REFERENCE

537830

STATEMENT DATE 4-3-01 TERMS

DRESS Ottawa County Health Coalition

ACCOUNT WITH Palazzo's

		Room fee		$ 64	89

Adams DCS812

STATEMENT DATE 6-5-01 TERMS

TO Ottawa County Health Coalition

ADDRESS

IN ACCOUNT WITH Palazzo's

		Room fee		63	89

Adams DCS812

001020

STATEMENT

DATE 1-23-01

TERMS

TO Ottawa County Health Co-alition

ADDRESS

IN ACCOUNT WITH Papazano's

		Room fee			58	99

Adams DC5812

STATEMENT

DATE 2-20-01

TERMS

TO Ottawa County Health Co-alition

ADDRESS

IN ACCOUNT WITH Papazano's

		Room fee			$65	89

Adams DC5812

004

Worker's Comp
9/29/2000 to 9/28/2001

Fund	Obj Code	Ref #	Amount
400BT11	1231	E33350	1.48
400BT11	1231	E38008	1.99
400BT11	1231	E48322	1.48
400BT11	1231	E56217	1.48
400BT11	1231	E58664	1.48
400BT11	1231	E63506	1.48
400BT11	1231	E68951	1.48
400BT11	1231	E74495	0.91
400BT11	1231	E79753	0.91
400BT11	1231	E79778	2.37
400BT11	1231	E33746	53.01
400BT11	1231	E38231	53.01
400BT11	1231	E48536	53.01
400BT11	1231	E56427	53.01
400BT11	1231	E58871	53.01
400BT11	1231	E63726	53.01
400BT11	1231	E69162	53.01
400BT11	1231	E74720	6.24
400BT11	1231	E80025	6.24
400BT11	1231	E34885	57.39
400BT11	1231	E38900	57.39
400BT11	1231	E49148	62.75
400BT11	1231	E57029	57.39
400BT11	1231	E59486	57.39
400BT11	1231	E64339	57.39
400BT11	1231	E69764	57.39
400BT11	1231	E75335	6.76
400BT11	1231	E80788	6.76
400BT11	1231	E34203	3.61
400BT11	1231	E38493	3.61
400BT11	1231	E48774	3.61
400BT11	1231	E56670	3.61
400BT11	1231	E59117	3.61
400BT11	1231	E69401	2.38
400BT11	1231	E74959	3.61
400BT11	1231	E80334	0.25
			843.61
400BT12	1231	F95712	0.89
400BT12	1231	F10288	0.93
400BT12	1231	020298	0.89
400BT12	1231	E86296	0.89
400BT12	1231	020298	(0.89)
400BT12	1231	E95776	2.24
400BT12	1231	F04205	2.24
400BT12	1231	F10309	2.24
400BT12	1231	E86505	5.88
400BT12	1231	E96333	5.88
400BT12	1231	F10499	6.90
400BT12	1231	E87104	6.37
400BT12	1231	E98085	7.20
400BT12	1231	F11100	6.78
400BT12	1231	F01575	3.11
400BT12	1231	F12466	3.09
			54.64
	Total Worker's Comp		**$ 898.15**

Time And Effort Cost
Cost Accumulation Schedule

December 26, 2001
Prepared By

Grant Name: Conduct Site Spec. Activities
Grant Number U50 / ATU686520-03
Grant Period 09/29/2000 TO 09/28/2001
Program Code 391

==ProgCost==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200010	91.03	168.57	0.00	704.31
200011	96.92	149.59	0.00	791.19
200012	62.26	111.22	0.00	1,208.53
200101	46.72	99.21	0.00	966.48
200102	60.50	115.88	0.00	747.34
200103	91.94	139.66	0.00	696.20
200104	77.55	196.02	0.00	1,059.63
200105	40.49	96.36	0.00	431.55
200106	46.17	153.10	0.00	910.81
200107	40.93	76.28	0.00	315.10
200108	58.71	120.59	0.00	577.18
200109	172.31	134.24	0.00	537.33
Total	**885.53**	**1,560.70**	**0.00**	**8,945.65**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200010	11.98	22.18	0.00	92.69
200011	9.38	14.48	0.00	76.59
200012	8.22	14.69	0.00	159.63
200101	4.81	10.22	0.00	99.52
200102	6.24	11.96	0.00	77.10
200103	10.41	15.81	0.00	78.82
200104	8.29	20.98	0.00	113.32
200105	4.49	10.69	0.00	47.90
200106	5.42	17.96	0.00	106.82
200107	4.26	7.94	0.00	32.81
200108	5.89	12.10	0.00	57.94
200109	34.55	26.92	0.00	107.75
Total	**113.94**	**185.91**	**0.00**	**1,050.89**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
103.01	190.75	0.00	797.00
106.30	164.07	0.00	867.78
70.48	125.91	0.00	1,368.16
51.53	109.43	0.00	1,066.00
66.74	127.84	0.00	824.44
102.35	155.47	0.00	775.02
85.84	216.98	0.00	1,172.95
44.98	107.05	0.00	479.45
51.59	171.06	0.00	1,017.63
45.19	84.20	0.00	347.91
64.60	132.69	0.00	635.12
206.86	161.16	0.00	645.08
999.47	**1,746.61**	**0.00**	**9,996.54**

INDIRECT COST SCHEDULE

Conduct Site Spec. Activities
U50 / ATU686520-03
09/29/2000 TO 09/28/2001

		SALARY	RATE	TOTAL
SFY	**2001**			
	On-Site	4,851.75	14.40 %	698.65
	Off-Site	76,725.66	7.80 %	5,984.60
SFY	**2002**			
	On-Site	1,119.48	35.00 %	391.82
	Off-Site	25,259.23	14.00 %	3,536.29
			Total Indirect Cost	10,611.36
			Federal Share of Indirect Cost	10,611.36

PERSONAL IDENTIFIER(S) REDACTED

STATE AND LOCAL RATE AGREEMENT

EIN #: 1736017987C4

DATE: August 1, 2001

DEPARTMENT/AGENCY:
Oklahoma State Department of Health
P.O. Box 53551
1000 NE Tenth St.
Oklahoma City OK 73117-1299

FILING REF.: The preced
Agreement was dated
May 31, 2000

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE(%)	LOCATIONS	APPLICABLE TO
FIXED	07/01/01	06/30/02	35.0	On Site	All Programs
FIXED	07/01/01	06/30/02	14.0	Off Site	All Programs
PROV.	07/01/02	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending June 30, 2002.		

*BASE:
Direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits.

STATE AND LOCAL RATE AGREEMENT

EIN #: 17360179870C4

DATE: May 31, 2000

DEPARTMENT/AGENCY:
Oklahoma State Department of Health
P.O. Box 53551
1000 NE Tenth St.
Oklahoma City OK 73117-1299

FILING REF.: The preceding Agreement was dated May 24, 1999

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE(%)	LOCATIONS	APPLICABLE TO
FIXED	07/01/00	06/30/01	14.4	On Site	All Programs
FIXED	07/01/00	06/30/01	7.8	Off Site	All Programs
PROV.	07/01/01	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending June 30, 2001.		

*BASE:
Direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits.

EQUIPMENT

9/29/2000 to 9/28/2001

Claims	-
PROGCOST - Equipment	-
Total Equipment	$ -

Claims are the direct costs and PROGCOST are the allocated costs. PROGCOST is allocated based on time charged to this program as a percentage of the total.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

DATE 6/26/2003

Oklahoma State Department of Health
State Cooperative Agreement Expenditures (SCA)
Superfund site (60BE), Tar Creek (Ottawa County) (OU2)
Ottawa County, Oklahoma

For the period 9/29/01 to 3/31/02

Personnel	$ 72,702.95
Fees	$ 982.13
Travel	$ 3,854.14
Equipment	$ 0.24
Other	$ 27,180.07
Indirect	$ 8,379.29
TOTALOKLAHOMA SCA COSTS	$ 113,098.82

PERSONAL IDENTIFIER(S) REDACTED

Oklahoma State Department of Health
Leslie M. Beitsch, MD
Commissioner of Health

June 20, 2003

Betty Jones
Cost Recovery Team Leader
1825 Century Boulevard
Mail Stop E-28 (OPOM)
Atlanta, Georgia 30345

RE: Tar Creek Documentation Requested for Cost Recovery (9/29/2001 to 3/31/2002)

Dear Ms. Jones,

In response to your request for Cost Recovery documentation I am sending you the enclosed information. This information covers the period 9/29/2001 to 3/31/2002 for the Program to Build Capacity to Conduct Site-Specific Environmental Health Education Monitoring Activities.

I have this documentation grouped with the same categories identified in the letter from Ken Cadaret to Richard Haj dated June 6, 2002. I have included all costs for this period that we can support with documentation.

If you have any additional question regarding the documentation provided please feel free to contact me at (405) 271-4042.

Respectfully,

Michael D. Truitt
Grants Supervisor
Financial Management Service

Board of Health
Ron L. Graves, DDS, President
John B. Carmichael, DDS
Jay A. Gregory, MD
Haskell L. Evans, Jr. RPh, Vice President
Gordon H. Deckert, MD
Ron Osterhout
Glen E. Dixson, Jr. MD, Treasurer
Dan H. Ficker, DO
Ann A. Warn, MD

1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us

TOTAL COSTS
9/29/2001 to 3/31/2002

Personnel	$ 72,702.95
Fees	982.13
Travel	3,854.14
Equipment	0.24
Other	27,180.07
IDC	8,379.29
Total	$ 113,098.82

PERSONAL IDENTIFIER(S) REDACTED

TOTAL PERSONNEL COSTS

9/29/2001 to 3/31/2002

TE005	62,408.47
PGM 301	10,614.17
Sub-Total	73,022.64
Adjustments to TE005	(319.69)
Total Personnel	$ 72,702.95

TE005 are the direct costs and PGM 301 are the allocated costs. PGM 301 is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

REPORT-ID=TE005

ALPHA SORT

OKLAHOMA DEPARTMENT OF HEALTH
LABOR DISTRIBUTION REPORT(PROGRAM CODE 391 ONLY)
PERIOD 10/01/2001 THRU 03/31/2002

DATE RUN 05/29/2003
PAGE 1

NAME (LAST)	F	PROG	ACT	TASK	OUT	BES	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
BUCK	J	391	010	000			0.67	0.13	0.80	0.4	9.37	2.83	12.20
		391	021	000			39.02	9.16	48.18	99.6	757.38	218.42	975.80
SUBTOTAL		391					39.69	9.29	48.98	100.0	766.75	221.25	988.00
TOTAL							39.69	9.29	48.98	100.0	766.75	221.25	988.00
CADARET	K	391	021	000			80.00	14.17	94.17	100.0	2331.54	759.80	3091.34
TOTAL							80.00	14.17	94.17	100.0	2331.54	759.80	3091.34
CORNELL	K	391	010	000			33.67	5.93	39.60	19.4	883.00	225.49	1108.49
		391	411	000			28.66	5.28	33.94	16.6	841.84	215.73	1057.57
		391	416	000			6.00	1.60	7.60	3.7	194.56	50.03	244.59
		391	416	001			1.33	0.13	1.46	0.7	29.93	7.61	37.54
		391	417	000		1	16.00	0.42	16.42	8.0	445.24	113.38	558.62
		391	418	000			44.33	5.79	50.12	24.5	1204.78	307.56	1512.34
		391	422	000			13.34	2.21	15.55	7.6	355.45	91.24	446.69
		391	422	001			2.03	0.22	2.25	1.1	56.11	14.26	70.37
		391	424	000			7.34	1.68	9.02	4.4	179.60	46.14	225.74
		391	426	000			4.68	0.51	5.17	2.5	145.93	37.52	183.45
		391	427	000			3.68	0.59	4.27	11.5	97.29	24.84	122.13
SUBTOTAL		391					161.04	24.36	185.40	100.0	4433.73	1133.80	5567.53
TOTAL							161.04	24.36	185.40	100.0	4433.73	1133.80	5567.53
DURBOROW	K	391	010	000			0.33	0.24	0.57	100.0	9.05	3.03	12.08
TOTAL							0.33	0.24	0.57	100.0	9.05	3.03	12.08
HORTON	N	391	010	000			62.58	4.34	66.92	37.9	1181.01	323.80	1504.81
		391	020	000			764.70	103.12	867.82	492.1	15532.53	4237.68	19770.21
		391	021	000			37.38	4.71	42.09	23.9	799.65	218.72	1018.37
		391	036	000			6.33	0.00	6.33	0.0	108.33	29.99	138.32
SUBTOTAL		391					870.99	112.17	983.16	553.9	17621.52	4810.19	22431.71
TOTAL							870.99	112.17	983.16	553.9	17621.52	4810.19	22431.71
LINN	J	391	021	000			10.33	0.68	11.01	100.0	151.83	45.64	197.47
TOTAL							10.33	0.68	11.01	100.0	151.83	45.64	197.47
NICHOLS	J	391	001	000			17.00	3.67	20.67	100.0	538.98	138.12	677.10
TOTAL							17.00	3.67	20.67	100.0	538.98	138.12	677.10
TIRRES	R	391	010	000			15.31	0.99	16.30	9.2	122.45	49.28	171.69
		391	020	000			518.36	63.30	581.66	326.8	4463.09	1800.72	6263.81
		391	021	000			356.66	44.55	401.21	225.4	3073.49	1236.62	4310.11
		391	036	000			6.00	0.00	6.00	0.0	48.18	19.80	67.78
SUBTOTAL		391					896.33	108.84	1005.17	561.4	7707.19	3106.20	10813.39
TOTAL							896.33	108.84	1005.17	561.4	7707.19	3106.20	10813.39

REPORT-ID=TE005 OKLAHOMA DEPARTMENT OF HEALTH DATE RUN 05/29/2003
LABOR DISTRIBUTION REPURT(PROGRAM CODE 391 ONLY) PAGE 2
ALPHA SORT PERIOD 10/01/2001 THRU 03/31/2002

NAME (LAST)	F	PROG ACT TASK OUT SEQ	HOURS	LEAVE HOURS	TOTAL HOURS	% OF TIME	SALARY COST	FRINGE COST	TOTAL COST
WALDRON	S	391 010 000	66.03	4.11	70.14	41.4	978.77	282.90	1261.67
		391 020 000	704.31	122.77	827.08	488.4	11720.89	3374.96	15095.85
		391 021 000	112.68	6.12	118.80	70.2	1665.36	481.33	2146.69
		391 036 000	6.67	0.00	6.67	0.0	97.39	28.25	125.64
SUBTOTAL		391	889.69	133.00	1022.69	600.0	14462.41	4167.44	18629.85
TOTAL			889.69	133.00	1022.69	600.0	14462.41	4167.44	18629.85
GRAND TOTAL			2,965.40		3,371.82		48,023.00		62,408.47
				406.42		100.0		14,385.47	

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	233	020		04	00	058						
2	08	318	021		02	00	058						
3	08	374	021		02	00	058						
4	09	340	021		03	20	058						
5	09	340	010		00	40	058						
6	09	241	021		03	00	058						
7	09	257	021		01	00	058						
8	10	250	001		02	00	058						
9	10	257	021		02	00	058						
10	10	266	021		03	20	058						
11	10	250	010		00	40	058						
12	11	301	003		08	00	058						
13	12	340	021		02	20	058						
14	12	340	010		00	40	058						
15	12	257	021		02	00	058						
16	12	391	021		03	00	058						
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month: 10 Year: 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	233	020		03	00	058						
2	22	0055	021		04	40	058						
3	22	0055	010		00	20	058						
4	23	0055	021		03	20	058						
5	23	2577	021		02	00	058						
6	23	0055	010		00	40	058						
7	23	9200	021		02	00	058						
8	24	233	020		01	40	058						
9	24	391	021		03	20	058						
10	24	2577	021		02	20	058						
11	24	391	010		00	40	058						
12	25	233	020		02	00	058						
13	25	0055	021		05	20	058						
14	25	3400	010		00	40	058						
15	26	2577	021		05	20	058						
16	26	2500	001		02	00	058						
17	26	2500	010		00	40	058						
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Janice Buck

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	250	001		03	00	058						
2	29	374	021		02	00	058						
3	29	266	010		00	40	058						
4	29	266	021		02	20	058						
5	30	233	020		02	40	058						
6	30	257	021		03	00	058						
7	30	005	021		01	40	058						
8	30	005	010		00	40	058						
9	31	005	021		02	00	058						
10	31	005	010		00	40	058						
11	31	391	021		03	00	058						
12	31	241	021		02	20	058						
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE L. BUCK
Employee ID: 2436

Month 12 Week 04 Year 2001

Last Update: 12-21-2001 11:27:32AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/17/2001	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
12/18/2001	166 - Non-Spec Consumer Protection	149 - Clerical	000 - General Duties	058 - Ottawa County Health Dept.	0200
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	241 - Family Planning	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0220
12/19/2001	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0320
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0200
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
12/20/2001	166 - Non-Spec Consumer Protection	149 - Clerical	000 - General Duties	058 - Ottawa County Health Dept.	0200
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	340 - TB Prev & Control\Elimination	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0040
	340 - TB Prev & Control\Elimination	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
12/21/2001	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0300
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300

	Mon 12/17	Tue 12/18	Wed 12/19	Thu 12/20	Fri 12/21	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature J Nichols

Print Date: 12/21/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE L. BUCK
Employee ID: 2436

Month 12 Week 02 Year 2001

Last Update: 1-7-2002 12:15:05PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/03/2001	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0340
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
12/04/2001	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	238 - Adolescent Health	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	340 - TB Prev & Control\Elimination	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
12/05/2001	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
12/06/2001	238 - Adolescent Health	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0200
	374 - Children First	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
12/07/2001	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0500
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0220
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0040

	Mon 12/03	Tue 12/04	Wed 12/05	Thu 12/06	Fri 12/07	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature J Nichols

Print Date: 1/7/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE L. BUCK
Employee ID: 2436
Location: 058 - Ottawa County Health Dept.

Month 2 Week 02 Year 2002

Last Update: 2-8-2002 12:11:10PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/04/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	301 - All Personal Health\Local Health	004 - Enforced Leave	000 - General Duties	058 - Ottawa County Health Dept.	0600
02/05/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/06/2002	166 - Non-Spec Consumer Protection	149 - Clerical	000 - General Duties	058 - Ottawa County Health Dept.	0200
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	340 - TB Prev & Control\Elimination	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
	340 - TB Prev & Control\Elimination	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
02/07/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0420
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
02/08/2002	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600

	Mon 2/04	Tue 2/05	Wed 2/06	Thu 2/07	Fri 2/08	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date:10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE L. BUCK
Employee ID: 2436
Location: 058 - Ottawa County Health Dept.

Month 2 Week 04 Year 2002

Last Update: 2-22-2002 2:20:40PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/18/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/19/2002	250 - Eldercare	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0400
	374 - Children First	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/20/2002	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0340
	340 - TB Prev & Control\Elimination	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
02/21/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
02/22/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0200
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0140

	Mon 2/18	Tue 2/19	Wed 2/20	Thu 2/21	Fri 2/22	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE L. BUCK
Employee ID: 2436
Location: 058 - Ottawa County Health Dept.

Month 2 Week 05 Year 2002

Last Update: 2-28-2002 3:00:17PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/25/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	241 - Family Planning	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/26/2002	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/27/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	374 - Children First	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/28/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200

	Mon 2/25	Tue 2/26	Wed 2/27	Thu 2/28	Total
Total Hours	8.00	8.00	8.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE L. BUCK
Employee ID: 2436
Location: 058 - Ottawa County Health Dept.

Month 3 Week 04 Year 2002

Last Update: 3-22-2002 11:37:21AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/18/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0240
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/19/2002	166 - Non-Spec Consumer Protection	149 - Clerical	000 - General Duties	058 - Ottawa County Health Dept.	0040
	238 - Adolescent Health	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	238 - Adolescent Health	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0100
	374 - Children First	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/20/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0300
03/21/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0240
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
03/22/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	250 - Eldercare	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0200
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	340 - TB Prev & Control\Elimination	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140
	340 - TB Prev & Control\Elimination	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature Jane Ann Nichols
cnb

Print Date: 3/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE L. BUCK
Employee ID: 2436
Location: 058 - Ottawa County Health Dept.

Month 3 Week 05 Year 2002

Last Update: 3-29-2002 4:19:33PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/25/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0200
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
03/26/2002	301 - All Personal Health\Local Health	004 - Enforced Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/27/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
03/28/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	241 - Family Planning	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	374 - Children First	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
03/29/2002	005 - Non-Agency Program Effort	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	005 - Non-Agency Program Effort	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	257 - WIC	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0220

	Mon 3/25	Tue 3/26	Wed 3/27	Thu 3/28	Fri 3/29	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Buck

Supervisor's Signature Jane Ann Nichols LMB

Print Date: 3/29/2002

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1/5

Employee Ken Cadaret

Month 10 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	021		04	00							
2	01	383	021		04	00							
3	02	383	021		04	00							
4	03	383	021		04	00							
5	04	383	021		04	00							
6	05	383	021		04	00							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature J.K

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3/5

Employee Kay Cadaret

Month 10 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	021		04	00							
2	08	383	021		04	00							
3	09	383	021		04	00							
4	10	383	021		08	00							
5	11	383	021		03	00							
6	11	383	008		05	00							
7	12	383	021		08	00							
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K Cadaret

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3/5

Employee Ken Cadaret

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	391	021		04	00							
2	15	383	021		04	00							
3	16	383	021		08	00							
4	17	383	021		08	00							
5	18	383	002		08	00							
6	19	383	002		08	00							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K— Cadaret

Supervisor's Signature S.K

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4/5

Employee Ken Cadaret

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month: 10 Year: 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	021		04	00							
2	22	383	021		04	00							
3	23	383	021		08	00							
4	24	383	021		08	00							
5	25	383	021		08	00							
6	26	383	021		08	00							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature K. Cadaret

Supervisor's Signature JK

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5/5

Employee Ken Cadanet

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	021		04	00							
2	29	383	021		04	00							
3	30	383	021		08	00							
4	31	383	021		08	00							
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature [signature]

Supervisor's Signature [signature]

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Last Update: 11-19-2001 8:57:58AM
Month 11 Week 03 Year 2001

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/12/2001	383 - Childhood Lead Poisoning Prev	009 - Holiday	000 - General Duties		0400
	391 - Capacity Building-Site Specific	009 - Holiday	000 - General Duties		0400
11/13/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
11/14/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
11/15/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
11/16/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 11/12	Tue 11/13	Wed 11/14	Thu 11/15	Fri 11/16	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

ENTERED
[illegible] 2001

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date:11/19/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Month 11 Week 04 Year 2001

Last Update: 11-26-2001 8:24:47AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/19/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
11/20/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
11/21/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
11/22/2001	383 - Childhood Lead Poisoning Prev	009 - Holiday	000 - General Duties		0800
11/23/2001	383 - Childhood Lead Poisoning Prev	009 - Holiday	000 - General Duties		0800

	Mon 11/19	Tue 11/20	Wed 11/21	Thu 11/22	Fri 11/23	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

DEC 05 2001

TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature _____

Print Date:11/26/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Last Update: 12-3-2001 9:18:32AM
Month 11 Week 05 Year 2001

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/26/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0500
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
11/27/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0700
	383 - Childhood Lead Poisoning Prev	004 - Enforced Leave	000 - General Duties		0100
11/28/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
	383 - Childhood Lead Poisoning Prev	010 - Travel	000 - General Duties		0300
11/29/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
11/30/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400

	Mon 11/26	Tue 11/27	Wed 11/28	Thu 11/29	Fri 11/30	Total
Total Hours	9.00	8.00	11.00	8.00	4.00	40.00

DEC 05 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 12/3/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Month 12 Week 02 Year 2001

Last Update: 12-11-2001 1:38:11PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/03/2001	383 - Childhood Lead Poisoning Prev	003 - Sick Leave	000 - General Duties		0300
	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0100
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
12/04/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
12/05/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
12/06/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
12/07/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 12/03	Tue 12/04	Wed 12/05	Thu 12/06	Fri 12/07	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

ENTERED
DEC 18 2001
TIME & [illegible]

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date:12/11/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Month 12 Week 03 Year 2001

Last Update: 12-17-2001 8:23:04AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/10/2001	383 - Childhood Lead Poisoning Prev	003 - Sick Leave	000 - General Duties		0800
12/11/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
12/12/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
12/13/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
12/14/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 12/10	Tue 12/11	Wed 12/12	Thu 12/13	Fri 12/14	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date:12/17/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Month 12 Week 04 Year 2001

Last Update: 12-27-2001 1:45:38PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/17/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
12/18/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		1100
12/19/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
12/20/2001	383 - Childhood Lead Poisoning Prev	002 - Annual Leave	000 - General Duties		0500
12/21/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 12/17	Tue 12/18	Wed 12/19	Thu 12/20	Fri 12/21	Total
Total Hours	8.00	11.00	8.00	5.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature S.K

Print Date:12/27/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Month 12 Week 05 Year 2001

Last Update: 12-27-2001 1:48:50PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/24/2001	383 - Childhood Lead Poisoning Prev	009 - Holiday	000 - General Duties		0800
12/25/2001	383 - Childhood Lead Poisoning Prev	009 - Holiday	000 - General Duties		0800
12/26/2001	383 - Childhood Lead Poisoning Prev	002 - Annual Leave	000 - General Duties		0800
12/27/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
12/28/2001	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 12/24	Tue 12/25	Wed 12/26	Thu 12/27	Fri 12/28	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 12/27/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Last Update: 1-2-2002 8:59:40AM

Month 1 Week 01 Year 2002

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/01/2002	383 - Childhood Lead Poisoning Prev	009 - Holiday	000 - General Duties		0800
01/02/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
01/03/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/04/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Tue 1/01	Wed 1/02	Thu 1/03	Fri 1/04	Total
Total Hours	8.00	8.00	8.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature _____

Print Date: 1/7/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Month 1 Week 02 Year 2002

Last Update: 1-15-2002 2:45:28PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/07/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
01/08/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/09/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/10/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/11/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 1/07	Tue 1/08	Wed 1/09	Thu 1/10	Fri 1/11	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 1/15/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Last Update: 1-22-2002 1:57:56PM
Month 1 Week 03 Year 2002

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/14/2002	383 - Childhood Lead Poisoning Prev	003 - Sick Leave	000 - General Duties		0400
	391 - Capacity Building-Site Specific	004 - Enforced Leave	000 - General Duties		0400
01/15/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/16/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/17/2002	383 - Childhood Lead Poisoning Prev	002 - Annual Leave	000 - General Duties		0800
01/18/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 1/14	Tue 1/15	Wed 1/16	Thu 1/17	Fri 1/18	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature _____

Print Date: 1/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Month 1 Week 04 Year 2002

Last Update: 1-25-2002 11:02:58AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/21/2002	383 - Childhood Lead Poisoning Prev	009 - Holiday	000 - General Duties		0400
	391 - Capacity Building-Site Specific	009 - Holiday	000 - General Duties		0400
01/22/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/23/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
01/24/2002	383 - Childhood Lead Poisoning Prev	010 - Travel	000 - General Duties		0500
	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0500
01/25/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 1/21	Tue 1/22	Wed 1/23	Thu 1/24	Fri 1/25	Total
Total Hours	8.00	8.00	8.00	10.00	8.00	42.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 1/28/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203

Last Update: 1-31-2002 9:33:48AM

Month 1 Week 05 Year 2002

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/28/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
01/29/2002	383 - Childhood Lead Poisoning Prev	010 - Travel	000 - General Duties		0700
	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0340
01/30/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0600
01/31/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0720

	Mon 1/28	Tue 1/29	Wed 1/30	Thu 1/31	Total
Total Hours	8.00	10.67	6.00	7.33	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature _____

Print Date: 1/31/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203
Location: 231 - Screening And Special Services

Month 3 Week 03 Year 2002

Last Update: 3-15-2002 10:07:15AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/11/2002	383 - Childhood Lead Poisoning Prev	003 - Sick Leave	000 - General Duties		0400
	391 - Capacity Building-Site Specific	003 - Sick Leave	000 - General Duties		0400
03/12/2002	383 - Childhood Lead Poisoning Prev	003 - Sick Leave	000 - General Duties		0800
03/13/2002	383 - Childhood Lead Poisoning Prev	003 - Sick Leave	000 - General Duties		0800
03/14/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
03/15/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 3/11	Tue 3/12	Wed 3/13	Thu 3/14	Fri 3/15	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 3/15/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203
Location: 231 - Screening And Special Services

Month 3 Week 04 Year 2002

Last Update: 3-20-2002 12:33:03PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/18/2002	383 - Childhood Lead Poisoning Prev	002 - Annual Leave	000 - General Duties		0400
	391 - Capacity Building-Site Specific	002 - Annual Leave	000 - General Duties		0400
03/19/2002	383 - Childhood Lead Poisoning Prev	008 - Compensatory Leave	000 - General Duties		0400
	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
03/20/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
03/21/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
03/22/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 3/18	Tue 3/19	Wed 3/20	Thu 3/21	Fri 3/22	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 3/25/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KENNETH K CADARET
Employee ID: 1203
Location: 231 - Screening And Special Services

Month 3 Week 05 Year 2002

Last Update: 4-3-2002 10:07:58AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/25/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties		0400
03/26/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
03/27/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
03/28/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800
03/29/2002	383 - Childhood Lead Poisoning Prev	021 - Program Support Service	000 - General Duties		0800

	Mon 3/25	Tue 3/26	Wed 3/27	Thu 3/28	Fri 3/29	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____

Supervisor's Signature _____

Print Date: 4/3/2002

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page _____

Employee KAREN K. CORNELL 002

Month 10 Year 01

Social Security Number - PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	288	426	001	04	00	001						
2	01	288	427	001	04	00	001						
3	02	288	417	001	02	00	001	002	001				
4	02	288	416	001	04	00	001						
5	02	288	422	001	01	00	001						
6	02	288	418	001	01	00	001						
7	03	288	431	001	02	00	001						
8	03	288	441	002	01	20	001						
9	03	288	421	001	03	00	001						
10	03	396	422	001	02	00	001						
11	04	288	418	001	05	00	001						
12	04	288	428	001	03	00	001						
13	05	391	416	001	01	20	058						
14	05	288	424	001	04	40	200						
15	05	288	418	001	02	00	001						
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee KAREN K. CORNELL C02

Month 10 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	[redacted]	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	301	008		08	00	001						
2	09	288	424	[redacted]	01	00	200						
3	09	288	418	[redacted]	01	00	001						
4	09	288	410	[redacted]	01	00	001						
5	09	288	021	[redacted]	01	00	001						
6	09	301	008	—	01	00	001						
7	09	301	003	—	03	00	001						
8	10	301	003	—	00	40	001						
9	11	391	010	[redacted]	02	40	058						
10	11	391	417	[redacted]	04	00	058	001					
11	11	391	418	[redacted]	02	40	058						
12	12	391	010		02	40	058						
13	12	391	418	[redacted]	06	00	058						
14	13	288	010	002	03	00	200						
15	13	288	420	002	10	00	200	015					
16	13	288	421	002	01	20	200						
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby by Yolanda Salcido

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee KAREN K CORNELL 002

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	288	416		02	20	001						
2	22	288	421	002	06	00	200						
3	22	288	010	001	02	00	200						
4	23	288	420	002	05	00	200	082	002				
5	23	288	421	002	02	00	200						
6	23	288	010	001	02	00	200						
7	24	288	421	002	08	00	200						
8	25	288	010		02	20	021						
9	25	288	417		05	00	021						
10	25	288	418		01	20	021						
11	26	391	010		02	40	058						
12	26	391	418		05	20	058						
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley by Steph

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228

Month 11 Week 01 Year 2001

Last Update: 11-16-2001 10:51:38AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/01/2001	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0600
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0200
11/02/2001	* 391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0340
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	0420

	Thu 11/01	Fri 11/02	Total
Total Hours	8.00	8.00	16.00

*ATSDR/OSDH Lead Grant

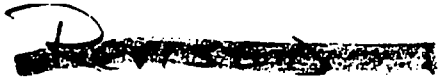
I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley

ENTERED
DEC 18 2001
TIME & EFFORT

Print Date: 11/16/2001



Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228

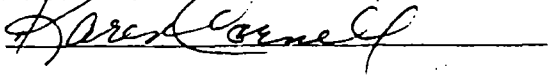
Month 11 Week 02 Year 2001

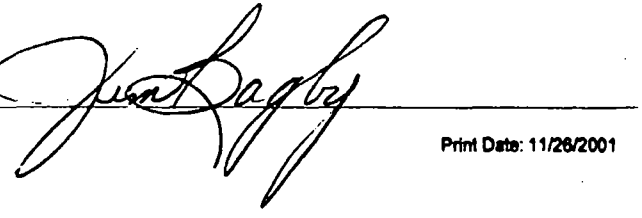
Last Update: 11-26-2001 10:57:47AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/05/2001	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	001 - Adair County Health Dept.	0740
11/06/2001	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0220
	288 - General Guidance Services	428 - Staff Continuing Education	000 - General Duties	001 - Adair County Health Dept.	0400
11/07/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0340
	391 - Capacity Building-Site Specific	411 - Screening	000 - General Duties	058 - Ottawa County Health Dept.	0600
11/08/2001	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0300
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0340
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0120
11/09/2001	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0600
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0220

	Mon 11/05	Tue 11/06	Wed 11/07	Thu 11/08	Fri 11/09	Total
Total Hours	7.67	6.33	9.67	8.00	8.33	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature 

Supervisor's Signature 

Print Date: 11/26/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228

Month 11 Week 04 Year 2001

Last Update: 11-26-2001 11:13:20AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/19/2001	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	001 - Adair County Health Dept.	0800
11/20/2001	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0240
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0400
11/21/2001	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0200
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0100
	391 - Capacity Building-Site Specific	427 - Support: Community Development	000 - General Duties	058 - Ottawa County Health Dept.	0100
11/22/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	001 - Adair County Health Dept.	0800
11/23/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	001 - Adair County Health Dept.	0800

	Mon 11/19	Tue 11/20	Wed 11/21	Thu 11/22	Fri 11/23	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley

Print Date: 11/26/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228

Month 11 Week 05 Year 2001

Last Update: 12-12-2001 12:49:49PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/26/2001	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	0100
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0300
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0320
11/27/2001	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0240
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	423 - Education Groups/Presentations	000 - General Duties	244 - Office Of Child Abuse Prevention	0200
	288 - General Guidance Services	424 - Support: Professional Consultation	000 - General Duties	244 - Office Of Child Abuse Prevention	0300
	391 - Capacity Building-Site Specific	424 - Support: Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0040
11/28/2001	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	001 - Adair County Health Dept.	0800
11/29/2001	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0500
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0300
	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	001 - Adair County Health Dept.	0300
11/30/2001	288 - General Guidance Services	010 - Travel	000 - General Duties	021 - Delaware County Health Dept.	0200
	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	021 - Delaware County Health Dept.	0200

	Mon 11/26	Tue 11/27	Wed 11/28	Thu 11/29	Fri 11/30	Total
Total Hours	8.00	9.00	8.00	11.00	4.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagby by P Stephens

Print Date: 12/12/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228

Month 12 Week 02 Year 2001

Last Update: 12-12-2001 1:37:08PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/03/2001	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0600
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0200
12/04/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/05/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	417 - Formal Psychological Evaluation	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/06/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	417 - Formal Psychological Evaluation	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/07/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	417 - Formal Psychological Evaluation	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 12/03	Tue 12/04	Wed 12/05	Thu 12/06	Fri 12/07	Total
Total Hours	8.00	8.00	8.00	8.00	10.00	42.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jean Bagley by [illegible]

Print Date: 12/12/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228

Month 12 Week 04 Year 2001

Last Update: 12-21-2001 4:12:12PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/17/2001	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0220
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0100
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0100
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0340
12/18/2001	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0300
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0100
	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	001 - Adair County Health Dept.	0400
12/19/2001	288 - General Guidance Services	416 - Support: Services to Individual Famil	000 - General Duties	001 - Adair County Health Dept.	0200
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0120
12/20/2001	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0400
12/21/2001	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0140
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0040
	391 - Capacity Building-Site Specific	427 - Support: Community Development	000 - General Duties	058 - Ottawa County Health Dept.	0140

	Mon 12/17	Tue 12/18	Wed 12/19	Thu 12/20	Fri 12/21	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley By P Stapp

Print Date: 12/21/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1226

Month 1 Week 02 Year 2002

Last Update: 1-11-2002 9:39:34AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/07/2002	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0140
	289 - Child Abuse Prevention	427 - Support: Community Development	000 - General Duties	001 - Adair County Health Dept.	0220
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0320
01/08/2002	231 - Child Health	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0220
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0200
	391 - Capacity Building-Site Specific	424 - Support: Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0340
01/09/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0220
	391 - Capacity Building-Site Specific	426 - Outreach and Promotion Activities	000 - General Duties	058 - Ottawa County Health Dept.	0120
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	0300
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0120
01/10/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0220
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0140
01/11/2002	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0140
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0200
	391 - Capacity Building-Site Specific	424 - Support: Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0300

	Mon 1/07	Tue 1/08	Wed 1/09	Thu 1/10	Fri 1/11	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley by PStephens

Print Date: 1/11/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228

Month 1 Week 04 Year 2002

Last Update: 1-25-2002 11:44:53AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/21/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	001 - Adair County Health Dept.	0800
01/22/2002	231 - Child Health	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0600
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0200
01/23/2002	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0240
	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	001 - Adair County Health Dept.	0520
01/24/2002	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0400
	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	001 - Adair County Health Dept.	0100
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0300
01/25/2002	231 - Child Health	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0240
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0240
	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0040
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	001 - Adair County Health Dept.	0100
	391 - Capacity Building-Site Specific	427 - Support: Community Development	000 - General Duties	058 - Ottawa County Health Dept.	0100

	Mon 1/21	Tue 1/22	Wed 1/23	Thu 1/24	Fri 1/25	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley by PS

Print Date: 1/25/2002

Oklahoma State Department of Health
Weekly (Program)
Month 1 Week 05 Year 2002

Employee: KAREN K CORNELL
Employee ID: 1228

Last Update: 2-1-2002 2:48:2

Activity Date	Program Code	ActivityCode	TaskCode	LocationCode	Time
01/28/2002	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	002(
Unit Out:	Number Sessions:	Col1: 02 Col2:	Col3:	Col4:	
01/28/2002	288 - General Guidance Services	416 - Support: Services to Individual Families	000 - General Duties	001 - Adair County Health Dept.	044(
01/28/2002	288 - General Guidance Services	425 - Community Planning Committees	265 - Child Abuse Prevention	001 - Adair County Health Dept.	002(
01/28/2002	391 - Capacity Building-Site Specific	416 - Support: Services to Individual Families	000 - General Duties	058 - Ottawa County Health Dept.	024(
01/29/2002	288 - General Guidance Services	425 - Community Planning Committees	265 - Child Abuse Prevention	001 - Adair County Health Dept.	030(
01/29/2002	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	052(
Unit Out: 001	Number Sessions: 001	Col1: 02 Col2:	Col3:	Col4:	
01/29/2002	288 - General Guidance Services	418 - Support: Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	010(
01/30/2002	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	044(
Unit Out: 001	Number Sessions: 001	Col1: 02 Col2:	Col3:	Col4:	
01/30/2002	288 - General Guidance Services	418 - Support: Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	020(
01/30/2002	288 - General Guidance Services	425 - Community Planning Committees	265 - Child Abuse Prevention	001 - Adair County Health Dept.	010(
01/31/2002	288 - General Guidance Services	418 - Support: Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	062(
01/31/2002	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	004(

	Mon 1/28	Tue 1/29	Wed 1/30	Thu 1/31	Total
Total Hours	8.00	9.33	7.67	7.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature: Karen Cornell

Supervisor's Signature: Jim Bagby by PS

Print Date: 2/1/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228
Location: 001 - Adair County Health Dept.

Month 2 Week 02 Year 2002

Last Update: 3-4-2002 10:53:24AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/04/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0420
	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0340
02/05/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0400
02/06/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0100
	288 - General Guidance Services	416 - Support: Services to Individual Fa	000 - General Duties	001 - Adair County Health Dept.	0140
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0020
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	001 - Adair County Health Dept.	0500
02/07/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0800
02/08/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0100
	391 - Capacity Building-Site Specific	427 - Support: Community Development	000 - General Duties	058 - Ottawa County Health Dept.	0300

	Mon 2/04	Tue 2/05	Wed 2/06	Thu 2/07	Fri 2/08	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID. 1228
Location: 001 - Adair County Health Dept.

Month 2 Week 03 Year 2002

Last Update: 2-15-2002 3:44:30PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/10/2002	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0300
	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	014 - Cleveland County Health Dept.	0320
02/11/2002	288 - General Guidance Services	429 - Technical Supervision	000 - General Duties	001 - Adair County Health Dept.	0540
	288 - General Guidance Services	423 - Education Groups/Presentations	000 - General Duties	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	014 - Cleveland County Health Dept.	0040
	288 - General Guidance Services	416 - Support: Services to Individual Fa	000 - General Duties	014 - Cleveland County Health Dept.	0120
02/12/2002	288 - General Guidance Services	429 - Technical Supervision	000 - General Duties	001 - Adair County Health Dept.	0600
	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	014 - Cleveland County Health Dept.	0300
02/13/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	014 - Cleveland County Health Dept.	0400
	288 - General Guidance Services	416 - Support: Services to Individual Fa	000 - General Duties	014 - Cleveland County Health Dept.	0100
	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0300
02/14/2002	288 - General Guidance Services	425 - Community Planning Committees	265 - Child Abuse Prevention	001 - Adair County Health Dept.	0200
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0140
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0220
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultatio	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/15/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0100
	288 - General Guidance Services	425 - Community Planning Committees	265 - Child Abuse Prevention	001 - Adair County Health Dept.	0220
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0020
	391 - Capacity Building-Site Specific	426 - Outreach and Promotion Activities	000 - General Duties	058 - Ottawa County Health Dept.	0320

	Sun 2/10	Mon 2/11	Tue 2/12	Wed 2/13	Thu 2/14	Fri 2/15	Total
Total Hours	6.33	9.00	9.00	8.00	8.00	7.00	47.33

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228
Location: 001 - Adair County Health Dept.

Month 2 Week 04 Year 2002

Last Update: 2-21-2002 3:54:01PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/17/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/18/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	001 - Adair County Health Dept.	0800
	391 - Capacity Building-Site Specific	411 - Screening	000 - General Duties	058 - Ottawa County Health Dept.	0720
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0240
02/19/2002	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0300
	391 - Capacity Building-Site Specific	411 - Screening	000 - General Duties	058 - Ottawa County Health Dept.	0420
02/20/2002	288 - General Guidance Services	416 - Support: Services to Individual Fa	000 - General Duties	001 - Adair County Health Dept.	0200
	391 - Capacity Building-Site Specific	411 - Screening	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/21/2002	288 - General Guidance Services	418 - Support: Formal Psychological Ev	000 - General Duties	001 - Adair County Health Dept.	0500
	391 - Capacity Building-Site Specific	411 - Screening	000 - General Duties	058 - Ottawa County Health Dept.	0300

	Sun 2/17	Mon 2/18	Tue 2/19	Wed 2/20	Thu 2/21	Total
Total Hours	2.00	18.00	8.00	4.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date:10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228
Location: 001 - Adair County Health Dept.

Month 3 Week 02 Year 2002

Last Update: 3-8-2002 8:50:09AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/04/2002	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0340
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0120
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	001 - Adair County Health Dept.	0200
	391 - Capacity Building-Site Specific	422 - Individual Professional Consultation	000 - General Duties	058 - Ottawa County Health Dept.	0020
03/05/2002	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0020
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0340
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0040
	391 - Capacity Building-Site Specific	416 - Support: Services to Individual Famil	000 - General Duties	058 - Ottawa County Health Dept.	0320
03/06/2002	288 - General Guidance Services	416 - Support: Services to Individual Famil	000 - General Duties	001 - Adair County Health Dept.	0200
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0440
03/07/2002	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0300
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0500
03/08/2002	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0500
	288 - General Guidance Services	416 - Support: Services to Individual Famil	000 - General Duties	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0100

	Mon 3/04	Tue 3/05	Wed 3/06	Thu 3/07	Fri 3/08	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley Jr PA

Print Date: 3/11/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228
Location: 001 - Adair County Health Dept.

Month 3 Week 03 Year 2002

Last Update: 3-15-2002 1:31:33PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/11/2002	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0240
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0120
03/12/2002	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0200
	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0500
	288 - General Guidance Services	441 - Non-Clinical Services	000 - General Duties	001 - Adair County Health Dept.	0100
03/13/2002	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0220
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	422 - Individual Professional Consultation	000 - General Duties	001 - Adair County Health Dept.	0200
	391 - Capacity Building-Site Specific	416 - Support: Services to Individual Famil	000 - General Duties	058 - Ottawa County Health Dept.	0100
03/14/2002	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0400
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0420
03/15/2002	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0300
	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	001 - Adair County Health Dept.	0020
	391 - Capacity Building-Site Specific	418 - Support: Formal Psychological Eval	000 - General Duties	058 - Ottawa County Health Dept.	0420

	Mon 3/11	Tue 3/12	Wed 3/13	Thu 3/14	Fri 3/15	Total
Total Hours	8.00	8.00	8.00	8.33	7.67	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Body

Print Date: 3/19/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: KAREN K CORNELL
Employee ID: 1228
Location: 001 - Adair County Health Dept.

Month 3 Week 04 Year 2002

Last Update: 3-26-2002 2:54:39PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/18/2002	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0220
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0320
	391 - Capacity Building-Site Specific	416 - Support: Services to Individual Famil	000 - General Duties	058 - Ottawa County Health Dept.	0220
03/19/2002	288 - General Guidance Services	416 - Support: Services to Individual Famil	000 - General Duties	001 - Adair County Health Dept.	0040
	288 - General Guidance Services	417 - Formal Psychological Evaluation	000 - General Duties	001 - Adair County Health Dept.	0520
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0240
03/20/2002	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0140
	288 - General Guidance Services	416 - Support: Services to Individual Famil	000 - General Duties	001 - Adair County Health Dept.	0200
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0420
03/21/2002	288 - General Guidance Services	427 - Support: Community Development	265 - Child Abuse Prevention	001 - Adair County Health Dept.	0120
	288 - General Guidance Services	411 - Screening	000 - General Duties	001 - Adair County Health Dept.	0100
	288 - General Guidance Services	418 - Support: Formal Psychological Eval	000 - General Duties	001 - Adair County Health Dept.	0400
03/22/2002	288 - General Guidance Services	010 - Travel	000 - General Duties	001 - Adair County Health Dept.	0600
	288 - General Guidance Services	426 - Outreach and Promotion Activities	265 - Child Abuse Prevention	001 - Adair County Health Dept.	0100
	288 - General Guidance Services	427 - Support: Community Development	265 - Child Abuse Prevention	001 - Adair County Health Dept.	0400

	Mon 3/18	Tue 3/19	Wed 3/20	Thu 3/21	Fri 3/22	Total
Total Hours	8.00	8.67	8.00	6.33	11.00	42.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Karen Cornell

Supervisor's Signature Jim Bagley

Print Date: 4/2/2002

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee KELLY DURBOROW

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	257	021		02	00	058						
2	22	257	020		03	00	058						
3	22	256	020		02	40	058						
4	22	266	010		00	20	058						
5	23	257	020		03	00	058						
6	23	256	020		03	00	058						
7	23	257	021		02	00	058						
8	24	256	020		04	00	058						
9	24	257	021		01	40	058						
10	24	257	020		02	00	058						
11	24	391	010		00	20	058						
12	25	257	020		03	00	058						
13	25	233	010		01	00	058						
14	25	233	020		01	00	058						
15	25	256	020		03	00	058						
16	26	257	010		01	20	018						
17	26	257	020		03	20	018						
18	26	256	020		03	20	018						

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Kelly Durborow

Supervisor's Signature Jennie Lin

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Nancy C. Horton

Month 10 Year 01

Social Security Number — PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	010		00	20	058						
2	01	391	020		08	00	058						
3	02	391	010		00	20	058						
4	02	391	020		07	40	058						
5	03	391	020		05	40	058						
6	03	391	010		03	40	058						
7	04	391	020		09	20	058						
8	04	391	010		03	40	058						
9	05	301	008		01	20	058						
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	021		01	40	058						
2	08	391	010		01	40	058						
3	08	391	020		07	00	058						
4	09	391	010		00	20	058						
5	09	391	020		08	40	058						
6	10	391	010		00	20	058						
7	10	391	020		08	40	058						
8	11	391	010		00	20	058						
9	11	391	020		07	40	058						
10	12	301	008		03	40	058						
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	391	020		07	00	058						
2	15	391	010		01	00	058						
3	16	391	020		08	20	058						
4	17	391	020		07	20	058						
5	18	391	020		08	40	058						
6	19	301	008		07	40	058						
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	010		01	20	058						
2	22	391	020		08	00	058						
3	23	391	010		00	20	058						
4	23	391	020		09	00	058						
5	24	391	010		00	20	058						
6	24	391	020		06	40	058						
7	25	391	010		04	00	058						
8	25	391	020		05	00	058						
9	26	391	020		07	40	058						
10	26	391	010		00	20	058						
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Nancy C. Horton

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	010		00	20	058						
2	29	391	020		08	00	058						
3	30	391	010		00	20	058						
4	30	391	020		07	40	058						
5	31	391	010		00	20	058						
6	31	391	020		09	40	058						
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 11 Week 05 Year 2001

Last Update: 11-30-2001 9:27:44AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/26/2001	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
11/27/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
11/28/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/29/2001	020 - Registered Sanitarians	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	058 - Ottawa County Health Dept.	0100
11/30/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020

	Mon 11/26	Tue 11/27	Wed 11/28	Thu 11/29	Fri 11/30	Total
Total Hours	7.67	8.33	8.00	7.67	8.33	40.00

ENTERED
DEC 11 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 11/30/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 11 Week 04 Year 2001

Last Update: 11-21-2001 2:30:38PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/19/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
11/20/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
11/21/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/22/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/23/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 11/19	Tue 11/20	Wed 11/21	Thu 11/22	Fri 11/23	Total
Total Hours	8.33	8.67	8.00	8.00	8.00	41.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 11/21/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 11 Week 02 Year 2001

Last Update: 11-9-2001 3:47:21PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/05/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/06/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0540
11/07/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
11/08/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
11/09/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740

	Mon 11/05	Tue 11/06	Wed 11/07	Thu 11/08	Fri 11/09	Total
Total Hours	8.33	8.67	8.00	8.00	8.00	41.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 11/9/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Last Update: 11-5-2001 8:35:54AM

Month 11 Week 01 Year 2001

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/01/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
11/02/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
11/03/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400

	Thu 11/01	Fri 11/02	Sat 11/03	Total
Total Hours	8.00	9.00	4.00	21.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 11/5/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Last Update: 12-31-2001 3:38:56PM
Month 12 Week 06 Year 2001

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/31/2001	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0720
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0040

	Mon 12/31	Total
Total Hours	8.00	8.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 12/31/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 12 Week 05 Year 2001

Last Update: 12-31-2001 3:30:01PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/24/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/25/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/26/2001	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0220
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0540
12/27/2001	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/28/2001	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400

	Mon 12/24	Tue 12/25	Wed 12/26	Thu 12/27	Fri 12/28	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 12/31/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 12 Week 04 Year 2001

Last Update: 12-21-2001 10:50:01AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/17/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	1000
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
12/18/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/19/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
12/20/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
12/21/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 12/17	Tue 12/18	Wed 12/19	Thu 12/20	Fri 12/21	Total
Total Hours	10.33	8.00	8.00	8.00	8.00	42.33

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 1/2/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 12 Week 03 Year 2001

Last Update: 12-14-2001 2:36:29PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/10/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0900
12/11/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
12/12/2001	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	058 - Ottawa County Health Dept.	0500
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
12/13/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
12/14/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 12/10	Tue 12/11	Wed 12/12	Thu 12/13	Fri 12/14	Total
Total Hours	9.00	8.33	6.00	8.67	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 12/14/2001

Amended

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 12 Week 02 Year 2001

Last Update: 12-10-2001 8:22:00AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/03/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
12/04/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
12/05/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
12/06/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
12/07/2001	~~020~~ 391 - ~~Registered Sanitarians~~	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

Should be
391 - Capacity Building - Site Specific
NCH Nancy C. Horton

	Mon 12/03	Tue 12/04	Wed 12/05	Thu 12/06	Fri 12/07	Total
Total Hours	8.33	7.67	7.67	8.33	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate

Employee's Signature Nancy C. Horton

Supervisor's Signature John Wilson

Print Date:12/10/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 1 Week 02 Year 2002

Last Update: 1-14-2002 11:03:04AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/07/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
01/08/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0920
01/09/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/10/2002	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0500
01/11/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 1/07	Tue 1/08	Wed 1/09	Thu 1/10	Fri 1/11	Total
Total Hours	8.33	9.67	8.00	6.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 1/14/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 1 Week 04 Year 2002

Last Update: 1-25-2002 1:03:52PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/21/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
01/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
01/23/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
01/24/2002	301 - All Personal Health\Local Health	004 - Enforced Leave	000 - General Duties	058 - Ottawa County Health Dept.	0140
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0620
01/25/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 1/21	Tue 1/22	Wed 1/23	Thu 1/24	Fri 1/25	Total
Total Hours	8.00	8.33	7.67	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 1/25/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 1 Week 03 Year 2002

Last Update: 1-22-2002 7:55:04AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/14/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
01/15/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0300
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
01/16/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
01/17/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0220
01/18/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0240

	Mon 1/14	Tue 1/15	Wed 1/16	Thu 1/17	Fri 1/18	Total
Total Hours	9.00	9.00	7.33	8.33	8.67	42.33

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 1/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241

Month 1 Week 05 Year 2002

Last Update: 2-1-2002 11:22:14AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/28/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0920
01/29/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0840
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
01/30/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
01/31/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 1/28	Tue 1/29	Wed 1/30	Thu 1/31	Total
Total Hours	9.33	9.00	8.00	8.00	34.33

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 2/1/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 2 Week 01 Year 2002

Last Update: 2-4-2002 1:16:39PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/01/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0120
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
02/02/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0340
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0120

	Fri 2/01	Sat 2/02	Total
Total Hours	8.00	5.00	13.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 2 Week 02 Year 2002

Last Update: 2-10-2002 3:21:12PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/04/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
02/05/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
02/06/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
02/07/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
02/08/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0140
	391 - Capacity Building-Site Specific	124 - Training	000 - General Duties	058 - Ottawa County Health Dept.	0620
02/09/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0520

	Mon 2/04	Tue 2/05	Wed 2/06	Thu 2/07	Fri 2/08	Sat 2/09	Total
Total Hours	8.33	8.67	7.00	7.67	8.00	5.33	45.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature _____

Print Date:10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 2 Week 03 Year 2002

Last Update: 2-26-2002 4:54:07PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/10/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0240
02/11/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0500
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
02/12/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/13/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/14/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0500
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
02/15/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400

	Sun 2/10	Mon 2/11	Tue 2/12	Wed 2/13	Thu 2/14	Fri 2/15	Total
Total Hours	2.67	8.00	8.00	8.00	11.00	4.00	41.67

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 2 Week 04 Year 2002

Last Update: 2-22-2002 3:20:01PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/18/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0840
02/19/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0940
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
02/20/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
02/21/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 2/18	Tue 2/19	Wed 2/20	Thu 2/21	Fri 2/22	Total
Total Hours	9.00	10.00	6.67	8.00	8.00	41.67

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date:10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 2 Week 05 Year 2002

Last Update: 3-1-2002 11:21:48AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/25/2002	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0120
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0540
02/26/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/27/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0900
02/28/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740

	Mon 2/25	Tue 2/26	Wed 2/27	Thu 2/28	Total
Total Hours	7.00	8.00	9.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 3 Week 01 Year 2002

Last Update: 3-1-2002 12:35:51PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/01/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740

	Fri 3/01	Total
Total Hours	8.00	8.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 3/1/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 3 Week 02 Year 2002

Last Update: 3-18-2002 9:57:04AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/04/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
03/05/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0840
03/06/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
03/07/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
03/08/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 3/04	Tue 3/05	Wed 3/06	Thu 3/07	Fri 3/08	Total
Total Hours	8.33	8.67	7.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 3/18/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 3 Week 03 Year 2002

Last Update: 3-18-2002 10:21:25AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/11/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0900
03/12/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
03/13/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
03/14/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0220
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
03/15/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400

	Mon 3/11	Tue 3/12	Wed 3/13	Thu 3/14	Fri 3/15	Total
Total Hours	9.67	8.33	8.00	9.00	8.00	43.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 3/18/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 3 Week 04 Year 2002

Last Update: 3-25-2002 3:53:08PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/18/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/19/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/20/2002	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0540
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/21/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/22/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 3/18	Tue 3/19	Wed 3/20	Thu 3/21	Fri 3/22	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 3/25/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: NANCY C. HORTON
Employee ID: 2241
Location: 058 - Ottawa County Health Dept.

Month 3 Week 05 Year 2002

Last Update: 3-29-2002 4:17:44PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/25/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
03/26/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0840
03/27/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/28/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
03/29/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 3/25	Tue 3/26	Wed 3/27	Thu 3/28	Fri 3/29	Total
Total Hours	8.33	8.67	8.33	8.67	8.00	42.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Nancy C. Horton

Supervisor's Signature Susan Waldron

Print Date: 3/29/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

3/22/02 9:49:16

Employee: JANICE M. LINN
Employee ID: 2678
Location: 058 - Ottawa County Health Dept.

Month 3 Week 03 Year 2002

Last Update: 3-14-2002 10:10:15AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/11/2002	241 - Family Planning	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0600
	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/12/2002	318 - Early Intervention	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0100
	318 - Early Intervention	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0400
	340 - TB Prev & Control\Elimination	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0300
03/13/2002	257 - WIC	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0100
	374 - Children First	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0100
	374 - Children First	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0600
03/14/2002	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	318 - Early Intervention	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	374 - Children First	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/15/2002	257 - WIC	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0200
	318 - Early Intervention	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0500

	Mon 3/11	Tue 3/12	Wed 3/13	Thu 3/14	Fri 3/15	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature J Nichols

Print Date: 3/14/2002

PERSONAL IDENTIFIER(S) REDACTED

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANICE M. LINN
Employee ID: 2678
Location: 058 - Ottawa County Health Dept.

Month 3 Week 04 Year 2002

Last Update: 3-22-2002 10:02:52AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/18/2002	318 - Early Intervention	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0300
	374 - Children First	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0100
	374 - Children First	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0400
03/19/2002	266 - Immunization	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0200
	266 - Immunization	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
03/20/2002	250 - Eldercare	001 - Administration	000 - General Duties	018 - Craig County Health Dept.	0400
	250 - Eldercare	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0100
	257 - WIC	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0200
	270 - STD Accelerated Prev	021 - Program Support Service	000 - General Duties	018 - Craig County Health Dept.	0100
03/21/2002	241 - Family Planning	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	270 - STD Accelerated Prev	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	340 - TB Prev & Control\Elimination	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/22/2002	374 - Children First	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400

	Mon 3/18	Tue 3/19	Wed 3/20	Thu 3/21	Fri 3/22	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Janice Linn

Supervisor's Signature Jane Ann Nichols
Lmb

Print Date: 3/22/2002

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee J. Nichols

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	301	010		01	20	018						
2	01	301	001		06	40	018						
3	02	301	001		08	00	058						
4	03	391	001		08	00	058						
5	04	301	003		08	00	058						
6	05	301	001		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

RECEIVED DEC 1 8 2001

Employee's Signature J. Nichols

Supervisor's Signature Stephen W. Ronck

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANE A NICHOLS
Employee ID: 1501

Month 12 Week 02 Year 2001

Last Update: 12-7-2001 1:24:44PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/03/2001	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/04/2001	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	018 - Craig County Health Dept.	0520
	301 - All Personal Health\Local Health	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0240
12/05/2001	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	018 - Craig County Health Dept.	0640
	301 - All Personal Health\Local Health	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0120
12/06/2001	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0700
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
12/07/2001	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0220
	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0540

	Mon 12/03	Tue 12/04	Wed 12/05	Thu 12/06	Fri 12/07	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

RECEIVED
DEC 1 8 2001
[illegible] SERVICES

Print Date: 12/17/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANE A NICHOLS
Employee ID: 1501

Month 12 Week 04 Year 2001

Last Update: 12-21-2001 12:32:40PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/17/2001	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0400
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
12/18/2001	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/19/2001	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/20/2001	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0200
	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0600
12/21/2001	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 12/17	Tue 12/18	Wed 12/19	Thu 12/20	Fri 12/21	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols

RECEIVED
JAN 0 [illegible] 2002
LOCAL HEALTH SERVICES

Supervisor's Signature Stephen W. Ronck

Print Date: 12/21/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: JANE A NICHOLS
Employee ID: 1501

Month 1 Week 05 Year 2002

Last Update: 1-31-2002 4:54:28PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/28/2002	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/29/2002	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0700
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
01/30/2002	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	058 - Ottawa County Health Dept.	0700
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
01/31/2002	301 - All Personal Health\Local Health	010 - Travel	000 - General Duties	018 - Craig County Health Dept.	0120
	301 - All Personal Health\Local Health	001 - Administration	000 - General Duties	018 - Craig County Health Dept.	0640

	Mon 1/28	Tue 1/29	Wed 1/30	Thu 1/31	Total
Total Hours	8.00	9.00	9.00	8.00	34.00

RECEIVED
FEB 11 8

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature J Nichols Supervisor's Signature Stephen W. Rourke

SERVICES

Print Date: 2/4/2002

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Renea Tirres Lane

Social Security Number _PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	391	010		01	00	058						
2	15	391	021		07	00	058						
3	16	391	020		06	00	058						
4	16	391	021		02	00	058						
5	17	391	020		04	00	058						
6	17	391	021		04	00	058						
7	18	391	020		05	00	058						
8	18	391	021		03	00	058						
9	19	391	020		06	00	058						
10	19	391	021		02	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Renea Lane

Supervisor's Signature Susan Waldron

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 4

Employee Remedios Lane

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	3911	010		00	20	058						
2	22	3911	020		05	40	058						
3	22	3911	021		02	00	058						
4	23	3911	010		00	40	058						
5	23	3911	021		03	20	058						
6	23	3911	020		04	00	058						
7	24	3911	010		00	20	058						
8	24	3911	020		04	40	058						
9	24	3911	021		03	00	058						
10	25	3911	010		00	40	058						
11	25	3911	020		03	20	058						
12	25	3911	021		04	00	058						
13	26	3911	010		00	40	058						
14	26	3911	020		04	20	058						
15	26	3911	021		03	00	058						
16													
17													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Lane

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Renedra Zinn

Social Security Number _ PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	020		03	00	058						
2	29	391	021		06	00	058						
3	30	391	010		00	40	058						
4	30	391	031		03	20	058						
5	30	391	030		04	00	058						
6	31	391	020		05	40	058						
7	31	391	010		00	30	058						
8	31	391	021		04	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Renedra Zinn

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Remedios Luis

Month 10 Year 01

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		06	00	058						
2	01	391	021		02	00	058						
3	02	391	020		04	00	058						
4	02	391	021		04	00	058						
5	03	391	020		06	00	058						
6	03	391	021		02	00	058						
7	04	391	020		04	00	058						
8	04	391	021		04	00	058						
9	05	391	008		08	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Luis

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Remedios Luna

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	~~Task Code~~	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	020	~~000~~	06	00	058						
2	08	391	021	~~001~~	02	00	058						
3	09	391	020	~~000~~	06	40	058						
4	09	391	010	~~000~~	00	30	058						
5	09	391	021	~~001~~	01	00	058						
6	10	391	010	~~000~~	00	20	058						
7	10	391	020	~~000~~	07	40	058						
8	11	391	020	~~000~~	04	00	058						
9	11	391	021	~~001~~	04	00	058						
10	12	391	020	~~000~~	04	00	058						
11	12	391	021	~~001~~	04	00	058						
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Luna

Supervisor's Signature Susan Waldron

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 11 Week 01 Year 2001

Last Update: 11-2-2001 9:58:06AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/01/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept. 0600	[redacted]
11/02/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Thu 11/01	Fri 11/02	Total
Total Hours	8.00	8.00	16.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 11/2/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 11 Week 02 Year 2001

Last Update: 11-9-2001 3:30:10PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/05/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/06/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/07/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/08/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/09/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 11/05	Tue 11/06	Wed 11/07	Thu 11/08	Fri 11/09	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 11/9/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 11 Week 04 Year 2001

Last Update: 11-28-2001 9:16:04AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/19/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/20/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/21/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/22/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/23/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 11/19	Tue 11/20	Wed 11/21	Thu 11/22	Fri 11/23	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 11/28/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 11 Week 05 Year 2001

Last Update: 11-30-2001 8:28:41AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/26/2001	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/27/2001	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/28/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/29/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
11/30/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 11/26	Tue 11/27	Wed 11/28	Thu 11/29	Fri 11/30	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

ENTERED
DEC 1 1 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 11/30/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 12 Week 02 Year 2001

Last Update: 12-7-2001 4:08:01PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/03/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/04/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/05/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/06/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/07/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 12/03	Tue 12/04	Wed 12/05	Thu 12/06	Fri 12/07	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 12/7/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 12 Week 03 Year 2001

Last Update: 12-14-2001 10:54:42AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/10/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/11/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	920 - Bioterrorism Preparedness	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
12/12/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/13/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
12/14/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 12/10	Tue 12/11	Wed 12/12	Thu 12/13	Fri 12/14	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 12/14/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 12 Week 04 Year 2001

Last Update: 12-21-2001 10:00:50AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/17/2001	[redacted]	[redacted]	[redacted]	[redacted]	0200 [redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	0800 [redacted]
12/18/2001	[redacted]	[redacted]	[redacted]	[redacted]	0800 [redacted]
12/19/2001	[redacted]	020 - Direct Program Service	[redacted]	[redacted]	0800 [redacted]
12/20/2001	301 - All Personnel Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	[redacted] NO
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
12/21/2001	[redacted]	[redacted]	[redacted]	[redacted]	0800 [redacted]

	Mon 12/17	Tue 12/18	Wed 12/19	Thu 12/20	Fri 12/21	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 12/21/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 12 Week 05 Year 2001

Last Update: 12-28-2001 11:40:05AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/24/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/25/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/26/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept. 0400	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept. 0500	[redacted]
12/27/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept. 0200	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept. 0700	[redacted]
12/28/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept. 0800	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept. 0700	[redacted]

	Mon 12/24	Tue 12/25	Wed 12/26	Thu 12/27	Fri 12/28	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 12/28/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Last Update: 12-31-2001 10:58:11AM
Month 12 Week 06 Year 2001

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/31/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0800 [redacted]

	Mon 12/31	Total
Total Hours	8.00	8.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 12/31/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Last Update: 1-7-2002 9:30:31AM

Month 1 Week 01 Year 2002

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/01/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/02/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/03/2002	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/04/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Tue 1/01	Wed 1/02	Thu 1/03	Fri 1/04	Total
Total Hours	8.00	8.00	8.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 1/7/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 1 Week 02 Year 2002

Last Update: 1-14-2002 10:45:24AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/07/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept. 0600	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/08/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/09/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/10/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept. 0600	[redacted]
01/11/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 1/07	Tue 1/08	Wed 1/09	Thu 1/10	Fri 1/11	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 1/14/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 1 Week 03 Year 2002

Last Update: 1-22-2002 8:06:42AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/14/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/15/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/16/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/17/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/18/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 1/14	Tue 1/15	Wed 1/16	Thu 1/17	Fri 1/18	Total
Total Hours	8.00	9.00	8.00	8.00	9.00	42.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 1/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 1 Week 04 Year 2002

Last Update: 1-25-2002 4:34:30PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/21/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/23/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/24/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/25/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 1/21	Tue 1/22	Wed 1/23	Thu 1/24	Fri 1/25	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 2/6/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295

Month 1 Week 05 Year 2002

Last Update: 1-31-2002 12:55:35PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/28/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/29/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/30/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
01/31/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	[redacted]

	Mon 1/28	Tue 1/29	Wed 1/30	Thu 1/31	Total
Total Hours	8.00	8.00	8.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 1/31/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 2 Week 01 Year 2002

Last Update: 2-4-2002 2:19:44PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/01/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
02/02/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0020
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0440

	Fri 2/01	Sat 2/02	Total
Total Hours	8.00	5.00	13.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 2 Week 02 Year 2002

Last Update: 2-11-2002 8:31:38AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/04/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
02/05/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
02/06/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
02/07/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
02/08/2002	391 - Capacity Building-Site Specific	124 - Training	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0200

	Mon 2/04	Tue 2/05	Wed 2/06	Thu 2/07	Fri 2/08	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 2 Week 03 Year 2002

Last Update: 2-15-2002 1:58:38PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/11/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
02/12/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/13/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/14/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
02/15/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 2/11	Tue 2/12	Wed 2/13	Thu 2/14	Fri 2/15	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date:10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 2 Week 04 Year 2002

Last Update: 2-26-2002 9:44:16AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/18/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/19/2002	390 - Primary Care Proj – OHCA	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/20/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
02/21/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
02/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 2/18	Tue 2/19	Wed 2/20	Thu 2/21	Fri 2/22	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 2 Week 05 Year 2002

Last Update: 2-28-2002 10:36:31AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/25/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
02/26/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
02/27/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
02/28/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600

	Mon 2/25	Tue 2/26	Wed 2/27	Thu 2/28	Total
Total Hours	8.00	8.00	8.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 3 Week 01 Year 2002

Last Update: 3-1-2002 8:41:33AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/01/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Fri 3/01	Total
Total Hours:	8.00	8.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 3/1/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 3 Week 02 Year 2002

Last Update: 3-6-2002 9:31:12AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/04/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
03/05/2002	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
03/06/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/07/2002	301 - All Personal Health\Local Health	002 - Annual Leave	000 - General Duties	058 - Ottawa County Health Dept.	0300
	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0500
03/08/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 3/04	Tue 3/05	Wed 3/06	Thu 3/07	Fri 3/08	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 3/6/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 3 Week 04 Year 2002

Last Update: 3-22-2002 2:36:40PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/18/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
03/19/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
03/20/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
03/21/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100

	Mon 3/18	Tue 3/19	Wed 3/20	Thu 3/21	Fri 3/22	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 3/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: REMEDIOS TIRRES
Employee ID: 4295
Location: 058 - Ottawa County Health Dept.

Month 3 Week 05 Year 2002

Last Update: 4-1-2002 9:20:13AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/25/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
03/26/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
03/27/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/28/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/29/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 3/25	Tue 3/26	Wed 3/27	Thu 3/28	Fri 3/29	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Remedios Tirres

Supervisor's Signature Susan Waldron

Print Date: 4/1/2002

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 1

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	01	391	020		08	00	058						
2	02	391	020		08	00	058						
3	03	391	010		00	40	058						
4	03	391	020		07	20	058						
5	04	391	020		08	00	058						
6	05	391	020		08	00	058						
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 2

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	08	391	010		01	40	058						
2	08	391	021		07	00	058						
3	08	391	020		02	20	058						
4	09	391	010		01	20	058						
5	09	391	020		07	40	058						
6	10	391	010		01	00	058						
7	10	391	020		07	00	058						
8	11	391	010		01	00	058						
9	11	391	020		06	00	058						
10	12	391	010		01	40	058						
11	12	391	020		06	00	058						
12													
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 3

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	15	391	010		01	20	058						
2	15	391	021		01	40	058						
3	15	391	020		05	00	058						
4	16	391	020		08	00	058						
5	17	391	010		00	40	058						
6	17	391	020		06	20	058						
7	17	301	008		01	00	058						
8	18	301	008		03	00	058						
9	18	391	020		05	00	058						
10	19	391	020		08	00	058						
11													
12													
13													
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I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	22	391	010		01	20	058						
2	22	391	021		03	00	058						
3	22	391	020		03	40	058						
4	23	233	010		01	00	058						
5	23	233	020		02	00	058						
6	23	391	020		05	00	058						
7	24	391	010		00	40	058						
8	24	391	020		07	20	058						
9	25	233	010		01	40	058						
10	25	233	021		02	20	058						
11	25	391	020		04	00	058						
12	26	391	020		08	00	058						
13													
14													
15													
16													
17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J. Nichols

ODH Form 4

Oklahoma State Department of Health

Time and Effort (T&E) Sheet

Page 5

Employee Susan Waldron

Social Security Number PERSONAL IDENTIFIER(S) REDACTED

Month 10 Year 01

Line #	Activity Date	Program Code	Activity Code	Task Code	Time Hours	Time Minutes	Location	Unit Out	Number Sessions	Program Data Column 1	Program Data Column 2	Program Data Column 3	Program Data Column 4
1	29	391	010		01	00	058						
2	29	391	020		07	00	058						
3	30	233	010		01	00	058						
4	30	233	020		03	00	058						
5	30	391	020		04	00	058						
6	31	391	010		01	00	058						
7	31	391	020		08	40	058						
8													
9													
10													
11													
12													
13													
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17													
18													

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

ODH Form 4

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 11 Week 05 Year 2001

Last Update: 11-30-2001 4:43:01PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/26/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/27/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/28/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/29/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/30/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 11/26	Tue 11/27	Wed 11/28	Thu 11/29	Fri 11/30	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

ENTERED
DEC 1 1 2001

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

Print Date: 11/30/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 11 Week 02 Year 2001

Last Update: 11-9-2001 4:13:40PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/05/2001	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/06/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/07/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
11/08/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
11/09/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720

	Mon 11/05	Tue 11/06	Wed 11/07	Thu 11/08	Fri 11/09	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

Print Date: 11/9/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 11 Week 01 Year 2001

Last Update: 11-6-2001 2:59:15PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
11/01/2001	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	058 - Ottawa County Health Dept.	0500
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
11/02/2001	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Thu 11/01	Fri 11/02	Total
Total Hours	8.00	8.00	16.00

ENTERED
DEC 0 6 2001
TIME & EFFORT

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

Print Date: 11/6/01

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1489

Month 12 Week 02 Year 2001

Last Update: 12-12-2001 10:21:19AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/03/2001	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/04/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/05/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
12/06/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/07/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 12/03	Tue 12/04	Wed 12/05	Thu 12/06	Fri 12/07	Total
Total Hours	8.00	8.00	7.33	8.67	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

Print Date: 12/12/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 12 Week 06 Year 2001

Last Update: 12-31-2001 10:51:36AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/31/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 12/31	Total
Total Hours	8.00	8.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Janice Lewis

Print Date: 12/31/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 12 Week 05 Year 2001

Last Update: 12-28-2001 2:37:07PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/24/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/25/2001	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/26/2001	301 - All Personal Health\Local Health	003 - Sick Leave	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/27/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/28/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100

	Mon 12/24	Tue 12/25	Wed 12/26	Thu 12/27	Fri 12/28	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J. Nichols

Print Date: 12/28/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 12 Week 04 Year 2001

Last Update: 12-21-2001 4:37:23PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/17/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0240
12/18/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
12/19/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0900
12/20/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0740
12/21/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140

	Mon 12/17	Tue 12/18	Wed 12/19	Thu 12/20	Fri 12/21	Total
Total Hours	9.67	8.00	9.00	7.67	7.67	42.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J Nichols

Print Date: 12/21/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Last Update: 12-21-2001 4:27:49PM

Month 12 Week 03 Year 2001

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
12/10/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
12/11/2001	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0120
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
12/12/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
12/13/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0240
12/14/2001	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0240

	Mon 12/10	Tue 12/11	Wed 12/12	Thu 12/13	Fri 12/14	Total
Total Hours	6.67	7.33	8.00	9.67	8.67	40.33

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

Print Date: 12/21/2001

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 1 Week 02 Year 2002

Last Update: 1-14-2002 10:01:33AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/07/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[illegible]
01/08/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[illegible]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[illegible]
01/09/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	[illegible]
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[illegible]
01/10/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[illegible]
01/11/2002	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	[illegible]

	Mon 1/07	Tue 1/08	Wed 1/09	Thu 1/10	Fri 1/11	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature J. Nichols

Print Date: 1/14/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Last Update: 1-29-2002 9:55:12AM

Month 1 Week 03 Year 2002

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/14/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/15/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0240
01/16/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0240
01/17/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0240
01/18/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 1/14	Tue 1/15	Wed 1/16	Thu 1/17	Fri 1/18	Total
Total Hours	8.00	8.67	8.67	8.67	6.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

Print Date: 1/29/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Month 1 Week 04 Year 2002

Last Update: 1-29-2002 10:17:19AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/21/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
01/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/23/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0240
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0520
01/24/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
01/25/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0300

	Mon 1/21	Tue 1/22	Wed 1/23	Thu 1/24	Fri 1/25	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

Print Date: 1/29/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469

Last Update: 2-1-2002 4:57:32PM

Month 1 Week 05 Year 2002

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/28/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
01/29/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
01/30/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0820
01/31/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720

	Mon 1/28	Tue 1/29	Wed 1/30	Thu 1/31	Total
Total Hours	8.00	8.33	8.33	7.33	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNO

Print Date: 2/1/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1489

Last Update: 1-7-2002 9:31:29AM

Month 1 Week 01 Year 2002

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
01/01/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/02/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/03/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
01/04/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Tue 1/01	Wed 1/02	Thu 1/03	Fri 1/04	Total
Total Hours	8.00	8.00	8.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature

Print Date: 1/7/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 2 Week 01 Year 2002

Last Update: 2-2-2002 3:14:39PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/01/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/02/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0320
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040

	Fri 2/01	Sat 2/02	Total
Total Hours	8.00	4.00	12.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature _____ Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 2 Week 02 Year 2002

Last Update: 2-26-2002 5:11:12PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/03/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
02/04/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0120
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0700
02/05/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0500
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0300
02/06/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/07/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/08/2002	391 - Capacity Building-Site Specific	124 - Training	000 - General Duties	058 - Ottawa County Health Dept.	0640
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0120

	Sun 2/03	Mon 2/04	Tue 2/05	Wed 2/06	Thu 2/07	Fri 2/08	Total
Total Hours	4.00	8.33	9.00	8.00	8.00	8.00	45.33

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature _____

Print Date:10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 2 Week 03 Year 2002

Last Update: 2-26-2002 5:16:01PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/11/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0500
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
02/12/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/13/2002	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/14/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0500
02/15/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0500

	Mon 2/11	Tue 2/12	Wed 2/13	Thu 2/14	Fri 2/15	Total
Total Hours	8.00	8.00	8.00	11.00	5.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 2 Week 04 Year 2002

Last Update: 2-27-2002 9:55:56AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/18/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
02/19/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/20/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/21/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
02/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0200
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0240
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0220

	Mon 2/18	Tue 2/19	Wed 2/20	Thu 2/21	Fri 2/22	Total
Total Hours	9.00	8.00	8.00	8.00	7.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature _____

Print Date:10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 2 Week 05 Year 2002

Last Update: 3-5-2002 8:26:24AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
02/25/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/26/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/27/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
02/28/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 2/25	Tue 2/26	Wed 2/27	Thu 2/28	Total
Total Hours	8.00	8.00	8.00	8.00	32.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature

Supervisor's Signature _____

Print Date: 10/30/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 3 Week 01 Year 2002

Last Update: 3-5-2002 8:29:14AM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/01/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Fri 3/01	Total
Total Hours	8.00	8.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols
mb

Print Date: 3/5/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 3 Week 02 Year 2002

Last Update: 3-22-2002 3:44:53PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/04/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/05/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/06/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/07/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/08/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0140
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0300
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0320

	Mon 3/04	Tue 3/05	Wed 3/06	Thu 3/07	Fri 3/08	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

Print Date: 3/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 3 Week 03 Year 2002

Last Update: 3-22-2002 3:38:00PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/11/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0100
03/12/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/13/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0600
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0120
03/14/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0320
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
03/15/2002	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0320
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0140

	Mon 3/11	Tue 3/12	Wed 3/13	Thu 3/14	Fri 3/15	Total
Total Hours	9.00	8.00	8.00	10.00	5.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols

Print Date: 3/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 3 Week 04 Year 2002

Last Update: 3-22-2002 3:11:36PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/18/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/19/2002	301 - All Personal Health\Local Health	009 - Holiday	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/20/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0720
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0040
03/21/2002	301 - All Personal Health\Local Health	008 - Compensatory Leave	000 - General Duties	058 - Ottawa County Health Dept.	0120
	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0640
03/22/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800

	Mon 3/18	Tue 3/19	Wed 3/20	Thu 3/21	Fri 3/22	Total
Total Hours	8.00	8.00	8.00	8.00	8.00	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols JR

Print Date: 3/22/2002

Oklahoma State Department of Health
Time and Effort (T&E) Sheet

Employee: SUSAN A WALDRON
Employee ID: 1469
Location: 058 - Ottawa County Health Dept.

Month 3 Week 05 Year 2002

Last Update: 3-29-2002 4:22:44PM

Activity Date	Program Code	Activity Code	Task Code	Location Code	Time
03/25/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
03/26/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
	391 - Capacity Building-Site Specific	021 - Program Support Service	000 - General Duties	058 - Ottawa County Health Dept.	0400
03/27/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0840
03/28/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0800
	391 - Capacity Building-Site Specific	010 - Travel	000 - General Duties	058 - Ottawa County Health Dept.	0100
03/29/2002	391 - Capacity Building-Site Specific	020 - Direct Program Service	000 - General Duties	058 - Ottawa County Health Dept.	0620

	Mon 3/25	Tue 3/26	Wed 3/27	Thu 3/28	Fri 3/29	Total
Total Hours	8.00	8.00	8.67	9.00	6.33	40.00

I certify that these statements are correct and that hours for each work period are accurate.

Employee's Signature Susan Waldron

Supervisor's Signature Jane Ann Nichols CNB

Print Date: 3/29/2002

Time And Effort Cost Accumulation Schedule

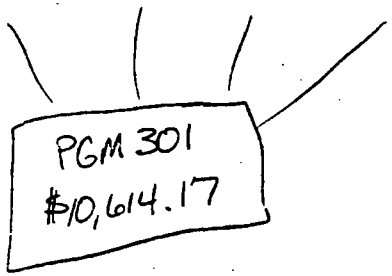
June 13, 2003

Prepared By _____

T & E Period: 10/2001 TO 03/2002

Program Code: 391

	TE009				PGM 244					
YearMont	On-Salary	On-Fringe	Off-Salary	Off-Fringe	On-Salary	On-Fringe	Off-Salary	Off-Fringe	Total Salary	Total Fringe
200110	666.41	191.30	7,593.95	2,257.25	0.00	0.00	0.00	0.00		
200111	207.65	68.40	7,700.01	2,250.35	0.00	0.00	0.00	0.00		
200112	521.09	171.65	7,771.92	2,292.17	0.00	0.00	0.00	0.00		
200201	305.60	107.19	7,789.00	2,334.34	0.00	0.00	0.00	0.00		
200202	513.25	180.03	7,721.63	2,322.14	0.00	0.00	0.00	0.00		
200203	117.54	41.23	7,114.95	2,169.42	0.00	0.00	0.00	0.00		
Total	**2,331.54**	**759.80**	**45,691.46**	**13,625.67**	**0.00**	**0.00**	**0.00**	**0.00**		
	PGM301				**TOTAL**					
200110	23.30	6.00	1,325.50	387.42	689.71	197.30	8,919.45	2,644.67	9,609.16	2,841.97
200111	6.20	1.72	1,081.45	312.57	213.85	70.12	8,781.46	2,562.92	8,995.31	2,633.04
200112	21.40	5.93	1,150.40	329.86	542.49	177.58	8,922.32	2,622.03	9,464.81	2,799.61
200201	13.21	3.83	1,115.81	337.02	318.81	111.02	8,904.81	2,671.36	9,223.62	2,782.38
200202	41.38	12.34	2,299.72	716.07	554.63	192.37	10,021.35	3,038.21	10,575.98	3,230.58
200203	4.82	1.44	1,083.07	333.71	122.36	42.67	8,198.02	2,503.13	8,320.38	2,545.80
Total	**110.31**	**31.26**	**8,055.95**	**2,416.65**	**2,441.85**	**791.06**	**53,747.41**	**16,042.32**	**56,189.26**	**16,833.38**



Adjustments to TE005 Report
9/29/2001 to 3/31/2002

	Total Hours	Total Cost	Per Hour Rate	Hours (Short)/Long	Cost Adjustment
1 J. Buck	39.69	988.00	24.89	(4.33)	**(107.77)**
3 K. Cornell	161.04	5,567.53	34.57	(3.00)	**(103.71)**
5 C. Horton	870.99	22,431.71	25.75	14.00	**360.50**
6 J. Linn	10.33	197.47	19.12	(4.33)	**(82.79)**
8 R. Tirres	896.33	10,813.39	12.06	(32.00)	**(385.92)**
					$ (319.69)

FEES

9/29/2001 to 3/31/2002

Claims	540.00
PROGCOST - Fees	442.13
Total Fees	$ 982.13

Claims are the direct costs and PROGCOST are the allocated costs. These are costs for professional services. Examples might be things like developing curricula for training materials or speaker fees.
PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	X027170	216486

FOR AGENCY USE
WARRANT # 7540010 DATE: 12/05/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	1582	932000000	540.00

CLAIM OF:
INTEGRIS BAPTIST REG HLTH CTR
730584411

2
1
6
4
8
6

FOR
$ 540.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARREN LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
004		540.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/15/2001	OCT 2001	540.00

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 1511AAAAAX 540.00

J/E XREF: 020659

VENDOR: INTEGRIS BAPTIST REG HLTH CTR
ADDRESS: ATTN: ANGEL HILL ACCTG
ADDRESS: PO BOX 1207
CITY/ST/ZIP: MIAMI OK 74355

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/28/2001

Title Date

Agency, Bd or Div. Use

2164846 ff

INVOICE

BAPTIST REGIONAL HEALTH CENTER
Attn: Angel Hill, Accounting
200 2nd S.W. - P.O. Box 1207
Miami, Oklahoma 74355
918-540-7282
FEI # 73-0584411

14-Nov-01

OKLAHOMA STATE DEPARTMENT OF HEALTH
ATTN: ACCOUNTS PAYABLE
1000 N.E. 10TH STREET
OKLAHOMA CITY, OK 73117-1299

PO# T078931 X027170

DESCRIPTION	CHARGES
Period covered @ $135.00/day:	
10/15/2001 Afton School	135.00
10/22/2001 Miami Middle School	135.00
10/25/2001 Picher School	135.00
10/26/2001 Quapaw Middle School	135.00
If you have questions regarding this invoice please contact Jennifer Hessee at (918)540-7492.	
PLEASE PAY THIS AMOUNT	$ 540.00

73058411

X027170 PURCHASE DOCUMENT
000235 ACCOUNT NO.
004 COMPLETE PARTIAL
4000 FUND NO.
35006 MATH CHECKED
15 OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
11/28/01 INVOICE APPROVED DATE

10

Financial Management Service

Return#: 15854

Invoice Rejected & Returned Unprocessed For The Reason(s) Indicated To:

Ken Cadaret/Family Health Services

Vendor Name: Baptist Regional Health Center

Vendor Number:

Invoice Number: Oct 2001 Invoice Date: 11/14/2001 Amount: $540.00

Order Number: X027170 Audited By: Ronney Maxwell Date Rejected: 11/19/2001

Funding

- [ ] Funding Not Indicated
- [ ] Does Not Match Encumbrance
- [ ] Invalid Fund
- [ ] Invalid Account
- [ ] Invalid Sub-Activity
- [ ] Invalid Object Code

Signature

- [ ] Vendor Signature
- [ ] Supervisor Signature
- [ ] Funding Block Signature

Verify The Following:

- [ ] Verify Vendor FEI #
- [ ] Verify Order #

Not Enough Allotment:

- [ ] 1st Quarter Allotment Insufficient
- [ ] 2nd Quarter Allotment Insufficient
- [ ] 3rd Quarter Allotment Insufficient
- [ ] 4th Quarter Allotment Insufficient

Need Additional Information:

- [ ] Certified Invoice Copy
- [ ] Proof of Delivery
- [ ] Notary Seal Missing
- [ ] Notary Signature Missing
- [ ] Notary County or State Incomplete
- [ ] Notary Expired (Not Valid)
- [ ] Changes Need Justification
- [ ] Changes Need Authorizing Initials
- [ ] Item Not Found

Mathematical Errors:

- [ ] Calculations Inaccurate
- [ ] Cross Footing Inaccurate
- [ ] Price Discrepancy

Encumbrance Problem:

- [ ] Invoice Exceeds Contract
- [ ] Invoice Exceeds Encumbrance
- [ ] Order Finalled

Required Dates:

- [ ] Invoice Date Prior to Date of Service
- [ ] Notary Date Prior to Date of Invoice
- [ ] Notary Date Prior to Date of Service

Other Remarks or Comments:

For your approval

11/21/01

11/21

Please Return This Document To Financial Management

1000 NE 10st Oklahoma City, OK 73117-1299 Room 315 (405) 271-4042

Time And Effort Cost
Cost Accumulation Schedule

June 13, 2003
Prepared By _____

Prog Cost Period: 10/2001 TO 03/2002
Program Code: 391

==ProgCost==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200110	85.29	186.98	0.21	845.04
200111	36.34	173.01	0.00	594.83
200112	79.59	117.27	0.00	870.41
200201	72.04	99.81	0.00	806.32
200202	59.00	75.58	0.00	590.28
200203	61.32	52.79	0.00	690.10
Total	**393.58**	**705.44**	**0.21**	**4,396.98**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200110	12.25	26.85	0.03	121.32
200111	4.08	19.40	0.00	66.71
200112	9.16	13.50	0.00	100.21
200201	8.61	11.93	0.00	96.35
200202	7.05	9.03	0.00	70.52
200203	7.40	6.37	0.00	83.27
Total	**48.55**	**87.08**	**0.03**	**538.38**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
97.54	213.83	0.24	966.36
40.42	192.41	0.00	661.54
88.75	130.77	0.00	970.62
80.65	111.74	0.00	902.67
66.05	84.61	0.00	660.80
68.72	59.16	0.00	773.37
442.13	**792.52**	**0.24**	**4,935.36**

TRAVEL

9/29/2001 to 3/31/2002

Claims	3,061.62
PROGCOST - Travel	792.52
Total Travel	$ 3,854.14

Claims are the direct costs and PROGCOST are the allocated costs. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15A
(Revised 1990)

** AGENCY COPY **

SVC CHF: NA

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y003067	227241

FOR AGENCY USE: WARRANT # 7905939 DATE: 03/22/2002

CLAIM OF:
CITICORP DINERS CLUB INC

PERSONAL IDENTIFIER(S) REDACTED

2
2
7
2
4
1

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	00001	2211	939910000	835.00
000235	42000	2211	939190000	417.50
000235	35001	2211	939940000	417.50
000220	20003	2211	939940000	2,081.50
000235	41000	2211	932000000	97.00
000220	20003	2211	935900000	415.50
000235	35005	2211	939940000	835.00

FOR
$ 5,099.00

AGAINST

Agency, Board, Comm', Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	5,099.00
050		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20020207

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/07/2002	38830035309	5,099.00

THIS SPACE FOR AGENCY USE

400AR22	000235NA0A	2211AAAAAX	835.00
400AR22	000235NC0A	2211AAAAAX	417.50
400AR22	000235TQ0A	2211AAAAAX	417.50
400B722	000220RQ97	2211AAAAAX	2081.50
400B812	000235NE0A	2211AAAAAX	97.00
400BI22	000220RV97	2211AAAAAX	415.50
400BT22	000235NW97	2211AAAAAX	835.00

J/E XREF:

VENDOR: CITICORP DINERS CLUB INC
ADDRESS: PO BOX 951013
ADDRESS:
CITY/ST/ZIP: DALLAS TX 753951013

ttach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices r contract estimates may be attached provided they are to the same vendor and against the ame contract, purchase or authorization order.

ach invoice must show on its face, the signature of the person who received and checked ie merchandise. Contractor estimates must be approved by the architect or engineer in arge of the project. Receiving reports may be submitted in lieu of signed invoices.

endors should file three copies of each invoice with the Department, Institution, or gency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer 03/06/2002

Title Date

Agency, Bd or Div. Use

Vendor # 383460736 OBJECT CODE 2211AAAAAA

INV 1/8/2002

Amount Due $27,778.00 2/7/02 Amount Paid $22,925.00

PO# Y003067

Richard Lorenz	NM	400AR22	000235NA0A	42000	$417.50	
Suzanna Dooley	NN	400AR22	000235NA0A	42000	$417.50	
Elizabeth Ramos	NO	400AR22	000235NC0A	42000	$417.50	
Marguerite Keesee	OM	400AR22	000235TQ0A	35001	$417.50	
Cara Vaught	NZ	400B722	000220RQ97	20003	$349.50	
Cara Vaught	OA	400B722	000220RQ97	20003	$415.50	
Cara Vaught	OB	400B722	000220RQ97	20003	$450.50	
Marshan Marick	OC	400B722	000220RQ97	20003	$450.50	
Marshan Marick	OD	400B722	000220RQ97	20003	$415.50	
Ginger Clark	MV	400B812	000235NE0A	41000	$97.00	
Ella Kay Siegel	NP	400BI22	000220RV97	20003	$415.50	
Susan Waldron	OS	400BT22	000235NW97	35005	$417.50	
Nancy Horton	OT	400BT22	000235NW97	35005	$417.50	
				Sub Total	$5,099.00	CL #227241 LIQ #050
Pam Archer	OK	400C322	0002205E0A	20006	$415.50	
Sheryll Brown	OJ	400C822	0002205E0A	20006	$418.50	
Anika Wilson	NY	400CD22	000220PG0A	20005	$473.00	
Rod Hargrave	MT	400CF22	000240WR0A	40001	$425.00	
Val Schott	MU	400CL22	000240WS0A	40001	$426.50	
Claudia Phillips	OU	400CL22	000240WS0A	40001	$425.00	
Kathy Payne	ON	400CM22	000235TS0A	35001	$417.50	
John Mathewson	NC	400CQ12	000220PB0A	20002	$415.50	
Kristy Bradley	MW	400CQ12	000220PB0A	20002	$415.50	
				Sub Total	$3,832.00	CL #227242 LIQ #051
Cassandra Edwards	OI	400CS22	000220EC0A	20006	$418.50	
Melanie Spector	NU	400CT22	000220PN97	20004	$198.00	
Nichole Diehl	OH	400CT22	000220PN97	20004	$439.50	
Peggy Byerly	OF	400CC22	000235NT0A	42000	$579.00	
Kenneth Cadaret	MX	400CX22	000235NN0A	35005	$415.50	
Amy Fletcher	NE	400CX22	000235NN0A	35005	$415.50	
Regina Glen	NA	400GK22	000255UE0A	55002	$403.50	
Claudia Phillips	OR	400HJX2	000201AV0A	00001	$385.00	
Denise Irish Hill	OQ	400JM22	000220CM0A	00001	$385.00	
				Sub Total	$3,639.50	CL #227253 LIQ #052
Kelly Baker	OO	192KAX2	010201CW0A	10003	$415.50	
Joyce Kirksey	OP	192KAX2	010201CW0A	10003	$415.50	
James Crutcher	NW	192KCX2	010220PI0A	20002	$218.00	
Patricia Hawkins	OE	192KFX2	010240WA0A	00001	$415.50	
Sharon Capps	MG	192KFX2	010240WN0A	00001	$282.00	
				Sub Total	$1,726.50	CL #227255 LIQ #053
Beverly Williams	NB	210VR12	000240WJ0A	40001	$202.00	
Espaniola Bowen	MS	210WLX2	000255UP0A	55001	$415.50	
				Sub Total	$617.50	CL #227257 LIQ #054
Sally Osburn	NL	270RAX2	000255DT0A	10002	$421.00	
Lee Roy Tucker	NK	270RAX2	000255DT0A	10002	$406.50	
				Sub Total	$827.50	CL #227259 LIQ #055
Stephen Bashore	NX	295RGX2	000255DM0A	10002	$424.50	
				Sub Total	$424.50	CL #227262 LIQ #056

PO# Y055717

Ella Kay Slagle	PD	400AP22	000220RU97	20003	$420.50	
Mary Ellen Finerty	OZ	400AR22	000235T40A	35005	$438.50	
Malinda Douglas	PB	400B812	000235NE0A	41000	$441.00	
Karen Coakley	PC	400B812	000235NE0A	41000	$441.00	
Tia Yancey	PF	400BI22	000220RV97	20003	$420.50	
Peng Li	PG	400BI22	000220RV97	20003	$420.50	
Linda Lamb	PH	400BI22	000220RV97	20003	$420.50	
Glenda Cross	PI	400BI22	000220RV97	20003	$420.50	
Mary Massey Douglas	PE	400BW22	000220RB97	20003	$420.50	
Boran Bursac	PM	400C222	000220RH97	20003	$420.50	
Shelli Stidham	PA	400C622	0002205E0A	20006	$420.50	
Catherine Montgomery	OV	400EA22	000235VA97	69000	$402.00	
Traci Lundy	OW	400EA22	000235VA97	69000	$402.00	
Janet Newport	OX	400EA22	000235VA97	69000	$411.00	
Pathi Hayes	OY	400EA22	000235VA97	69000	$411.00	
				Sub Total	**$6,310.50**	CL #227273 LIQ #001
Robert Vincent	PL	192KAX2	010201AA0A	00001	$448.00	
				Sub Total	**$448.00**	CL #227276 LIQ #002

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

[illegible]

[illegible]

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVISION
ORDERED BY ANNIE [illegible]
PURCHASE ORDER NUMBER [illegible]

FOR: WALDRON/SUSAN

DELTA TICKETLESS CONFIRMATION NBR [illegible]

11 FEB 02 - MONDAY

AIR	DELTA AIR LINES INC FLT:1618	COACH	
	LV TULSA	705A	EQP: BOEING 737-[illegible]
			01HR 50MIN
	AR ATLANTA	955A	NON-STOP
	ARRIVE: SOUTH TERMINAL		REF: [illegible]
	WALDRON/SUSAN SEAT-13C		

14 FEB 02 - THURSDAY

AIR	DELTA AIR LINES INC FLT:[illegible]	COACH	
	LV ATLANTA	[illegible]OP	EQP: BOEING 737-[illegible]
	DEPART: SOUTH TERMINAL		[illegible]
	AR TULSA	[illegible]11P	NON-STOP
			REF: [illegible]
	WALDRON/SUSAN SEAT-19C		

AIR TICKET DL7076598781 WALDRON SUSAN
ELEC TKT BILLED TO PERSONAL IDENTIFIER(S) REDACTED [illegible]

SUB TOTAL [illegible]
NET CC BILLING [illegible]

TOTAL AMOUNT DUE [illegible]

Disc 0.94

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES

[illegible]

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS.
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS.

leave from Tulsa

PROCUREMENT DIVISION PROCUREMENT DIVISION

OKLAHOMA STATE DEPARTMENT OF HEALTH
INTERSTATE TRAVEL REQUEST/AUTHORIZATION

2002 JAN 22 P 2:25 2002 JAN 25 P 3:09

DIVISION: Ottawa County Health Dept. / Community Health Services

APPLICANT: Susan Waldron POSITION (Title): Health Educator

NATURE OF TRIP: 2002 National Lead Health Education Conference

The Mission Is Possible: Lead Safe Kids (Name) 2/11/02-2/14/02 (Date) Atlanta, GA (Location)

JUSTIFICATION FOR TRIP: As coordinator of Ottawa County's Lead Poisoning Prevention Program, I have been asked to present 2 breakout sessions on successful project implemtation in 2 sessions, one on 2/12 and another 2/14. Funding for this travel is available through Ottawa County's Lead grant through ATSDR

DEPARTURE: 2/11/02 Early morning need to there by 3:30 DW DATE OF RETURN: 2/14/02 4:00-6:00 pm

MODE OF TRANSPORTATION (Private – Public): Airline Ticket: X Car: _____ Bus: _____
(If traveling by car a cost comparison must be attached)

DURATION OF TRIP WILL INCLUDE: 4 DAYS AT MEETING AND 2 DAYS ENROUTE

TOTAL NUMBER OF DAYS: 4

ESTIMATED COST: $ ~~345.00~~ 417.50 (Travel) $ 152.00 (Per Diem) $ 400.00 (Other) motel $ ~~797.00~~ 969.50 (Total)

APPROVED

J Nichols / SW
(Division Director/Service Chief)

FINANCIAL MANAGEMENT

Ottawa Co Lead Grant

FUNDING: 400BT22 (Fund) 000235NW97 (Account) 35005 (Sub-Activity) 93.200 (CFDA #)

Reimbursed by _____
(Used when non-OSDH resources are covering the entire cost of the meeting)

[signature] 01/24/02
(Financial Management Approval)

APPROVAL AND TRAVEL AUTHORIZATION

The individual named is authorized to perform official travel as indicated:

Steven W. Ronck (Name) Deputy Com (Title) 1-17-02 (Date)
(Executive Director/Deputy Commissioner/Commissioner)

OSDH Form No. 81
(Rev 10/2000)

Y003067-OS

TRAVEL AGENTS INCORPORATED

9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

[illegible]

OK. STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLV TO [illegible]
ORDERED BY ANGIE [illegible]
PURCHASE ORDER NUMBER [illegible]

FOR: HORTON/NANCY

DELTA [illegible] CONFIRMATION NBR [illegible]

[illegible] FEB 98 - [illegible]

AIR DELTA AIR LINES INC FLT:1619 COACH
LV TULSA 705A EQP: BOEING 737 800
2HRS 50MIN
AR ATLANTA 955A NON-STOP
ARRIVE: SOUTH TERMINAL REF: VYGALA
HORTON/NANCY SEAT-19C

[illegible] FEB 98 - THURSDAY
AIR DELTA AIR LINES INC FLT:[illegible] COACH
LV ATLANTA 510P EQP: BOEING 737-800
DEPART: SOUTH TERMINAL 01HR 51MIN
AR TULSA 61[illegible]P NON-STOP
REF: VYGALA
HORTON/NANCY SEAT-19D

AIR TICKET DL 7026598782 HORTON NANCY
ELEC TKT BILLED TO PERSONAL IDENTIFIER(S) REDACTED 417.50A

SUB TOTAL 417.50
NET CC BILLING 417.50*

TOTAL AMOUNT DUE 0.00

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES

Due 0.94

[illegible]

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE FOR INTERNATIONAL FLIGHTS
WE SUGGEST YOU RECONFIRM 48 HOURS IN ADVANCE FOR DOMESTIC FLIGHTS

PROCUREMENT DIVISION

PROCUREMENT DIVISION

OKLAHOMA STATE DEPARTMENT OF HEALTH
INTERSTATE TRAVEL REQUEST/AUTHORIZATION

2002 JAN 25 P 3:09

2002 JAN 22 P 3:54

DIVISION: Community Health Services \ Ottawa County Health Dept.

APPLICANT: Nancy C. Horton POSITION (Title): PHN II - Program Grant Consultan

NATURE OF TRIP: 2002 National Lead Health Conference

The Mission is Possible: Lead Safe Kids (Name) Feb 11-14 (Date) Atlanta, Georgia (Location)

JUSTIFICATION FOR TRIP: Breakout Sessions presentations for 2 separate sessions on successful Lead Poisoning Prevention Programs - funding Provided through ATSDR grant for Ottawa County Lead Project

DEPARTURE: 2-11-02 DATE OF RETURN: 2-14-02

MODE OF TRANSPORTATION (Private – Public): Airline Ticket: ✓ Car: _____ Bus: _____
(If traveling by car a cost comparison must be attached)

DURATION OF TRIP WILL INCLUDE: 4 DAYS AT MEETING AND 2 DAYS ENROUTE

TOTAL NUMBER OF DAYS: 4

ESTIMATED COST: $ ~~345.00~~ 417.50 (Travel) $ 152.00 (Per Diem) $ 93/night 300 (Other) $ ~~797.00~~ 869.5 (Total)

APPROVED

J Nichols / SW
(Division Director/Service Chief)

FINANCIAL MANAGEMENT

Ottawa Co Lead Grant

FUNDING: 400BT22 (Fund) 000235NW97 (Account) 35005 (Sub-Activity) 93.200 (CFDA #)

Reimbursed by _____
(Used when non-OSDH resources are covering the entire cost of the meeting)

[signature] 01/24/02
(Financial Management Approval)

RECEIVED 2002 JAN 25 P 12:16

APPROVAL AND TRAVEL AUTHORIZATION

The individual named is authorized to perform official travel as indicated:

Stephen W. Ponck — Deputy Comm. 1-17-02
Name Title
(Executive Director/Deputy Commissioner/Commissioner) (Date)

OSDH Form No. 81
(Rev 10/2000)

Y003067-OT

Corporate/Government Statement

Diners Club International

PAYMENT COUPON

PERSONAL IDENTIFIER(S) REDACTED

ACCOUNT:
Billing Date: 02-07-02
Payment Due: 03-03-02

TOTAL DUE: $45,898.25

M006956 C S

DINERS CLUB
P. O. BOX 851013
DALLAS, TX
USA 75385-1013

OK-340 DEPT OF HEALTH
ACCOUNTS PAYABLE
1000 NE 10TH STREET
OKLAHOMA CITY OK 73117-120700

PERSONAL IDENTIFIER(S) REDACTED

( ) _____ ( ) _____
New Home Phone *New Business Phone*
Please Print Change of Address or Phone Number above.

PAYMENT SUMMARY

ACCOUNT:
Billing Date: 02-07-02
Payment Due: 03-03-02

TOTAL DUE: $45,898.25

PERSONAL IDENTIFIER(S) REDACTED

We have not received your payment in full. Please contact Customer Service at 1-800-2-DINERS (1-800-234-6377) anytime -- 24 hours a day, 7 days a week. The best days to call are Wednesday through Friday. From outside the U.S., CALL US COLLECT AT 1-702-797-5532.

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
TRANSACTIONS FOR SUMMARY		OK-340 DEPT OF HEALTH		
01-15-02	PAYMENT - THANK YOU	LC5280150122		$3,184.00
01-15-02	PAYMENT - THANK YOU	LC5280150123		2,269.25
01-15-02	PAYMENT - THANK YOU	LC5280150124		2,113.50
01-15-02	PAYMENT - THANK YOU	LC5280150125		415.00
01-15-02	PAYMENT - THANK YOU	LC5280150126		415.00
01-15-02	PAYMENT - THANK YOU	LC5280150127		640.50
01-15-02	PAYMENT - THANK YOU	LC5280150128		159.50
	TOTAL FOR:			$9,206.75

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT: PERSONAL IDENTIFIER(S) REDACTED
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
	TRANSACTIONS FOR SUB-ACCOUNT .LS AGENTS			
01-10-02	AMERICAN AIRLINES TRAVLR: HARGRAVE/R TICKET NUM: 0017063906689 DEPARTURE DATE: 01/29/02 OKLAHOMA CI:N:CHICAGO CHICAGO:N:WASHINGTON WASHINGTON :N:DALLAS/FT. DALLAS/FT. :N:OKLAHOMA CI	I1F04135	$425.00	
01-10-02	AMERICAN AIRLINES TRAVLR: SCHOTT/V TICKET NUM: 0017063906690 DEPARTURE DATE: 01/29/02 OKLAHOMA CI:N:CHICAGO CHICAGO:N:WASHINGTON WASHINGTON :N:CHICAGO CHICAGO:N:OKLAHOMA CI	I1F04138	426.50	
01-10-02	AMERICAN AIRLINES TRAVLR: CAPPS/S TICKET NUM: 0017063906691 DEPARTURE DATE: 02/19/02 TULSA:N:DALLAS/FT. DALLAS/FT. :N:EL PASO EL PASO:N:DALLAS/FT. DALLAS/FT. :N:TULSA	I1F04137	262.00	
01-10-02	DELTA AIR LINES TRAVLR: BOWEN/E TICKET NUM: 0067063906688 DEPARTURE DATE: 02/10/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1F10323	415.50	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT: PERSONAL IDENTIFIER(S) REDACTED
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-10-02	SOUTHWEST AIRLINES TRAVLR: CLARK/GINGER TICKET NUM: 5262786879990 DEPARTURE DATE: 02/28/02 OKLAHOMA CI:Y:DALLAS/FT.	29651356	$97.00	
01-11-02	DELTA AIR LINES TRAVLR: BRADLEY/K TICKET NUM: 0067063906728 DEPARTURE DATE: 03/21/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1G12849	415.50	
01-11-02	DELTA AIR LINES TRAVLR: CADARET/K TICKET NUM: 0067063906727 DEPARTURE DATE: 02/11/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1G12850	415.50	
01-11-02	SOUTHWEST AIRLINES TRAVLR: FREEMAN/MELTO TICKET NUM: 5262786866285 DEPARTURE DATE: 01/30/02 OKLAHOMA CI:Y:ST. LOUIS ST. LOUIS:Y:OKLAHOMA CI	29779186	156.50	
01-11-02	SOUTHWEST AIRLINES TRAVLR: BRYCE/TERRY TICKET NUM: 5262786866474 DEPARTURE DATE: 01/30/02 OKLAHOMA CI:Y:ST. LOUIS ST. LOUIS:Y:OKLAHOMA CI	29779194	156.50	
01-14-02	CONTINENTAL AIR/CR MGMT TRAVLR: ATKINSON/N TICKET NUM: 0057063906517	D1E03860		$390.00

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-14-02	CONTINENTAL AIR/CR MGMT TRAVLR: CAPPS/S TICKET NUM: 0057063906544	D1E03861		$342.00
01-14-02	CONTINENTAL AIR/CR MGMT TRAVLR: WILLIAMS/B TICKET NUM: 0057063906737 DEPARTURE DATE: 01/29/02 OKLAHOMA CI:T:HOUSTON HOUSTON:T:NEW ORLEANS NEW ORLEANS:T:HOUSTON HOUSTON:T:OKLAHOMA CI	V1F05950	$202.00	
01-14-02	DELTA AIR LINES TRAVLR: GLEN/R TICKET NUM: 0067063906736 DEPARTURE DATE: 01/15/02 OKLAHOMA CI:Q:ATLANTA ATLANTA:Q:TAMPA/ST. P TAMPA/ST. P:Q:DALLAS/FT. DALLAS/FT. :Q:OKLAHOMA CI	V1F09691	403.50	
01-16-02	NATL RR PASS CORP TRAVLR: JAMES/V TICKET NUM: 5547063906777 DEPARTURE DATE: 01/27/02 FORT WORTH :1:SAN ANTONIO SAN ANTONIO:1:FORT WORTH	D1I21913	59.00	
01-17-02	CONTINENTAL AIR/CR MGMT TRAVLR: STONECIPHER/T TICKET NUM: 0057063906798 DEPARTURE DATE: 01/27/02 OKLAHOMA CI:T:HOUSTON HOUSTON:T:SAN ANTONIO SAN ANTONIO:T:HOUSTON HOUSTON:T:OKLAHOMA CI	I1J05995	212.00	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-17-02	DELTA AIR LINES TRAVLR: MATHEWSON/J TICKET NUM: 0067063906791 DEPARTURE DATE: 03/21/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1J09876	$415.50	
01-17-02	DELTA AIR LINES TRAVLR: SCHMAELZLE/J TICKET NUM: 0067063906792 DEPARTURE DATE: 02/10/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1J09877	432.50	
01-17-02	DELTA AIR LINES TRAVLR: FLETCHER/A TICKET NUM: 0067063906793 DEPARTURE DATE: 02/11/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1J09878	415.50	
01-17-02	DELTA AIR LINES TRAVLR: KINNEY/S TICKET NUM: 0067063906798 DEPARTURE DATE: 03/03/02 OKLAHOMA CI:Y:DALLAS/FT. DALLAS/FT. :Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1J09879	431.00	
01-17-02	UNITED AIRLINES TRAVLR: BRADLEY/K TICKET NUM: 0167063906797 DEPARTURE DATE: 02/14/02 OKLAHOMA CI:S:DENVER DENVER:S:OKLAHOMA CI	I1J16370	425.50	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT: PERSONAL IDENTIFIER(S) REDACTED
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-17-02	SOUTHWEST AIRLINES TRAVLR: BEITSCH/LESLI TICKET NUM: 5282787589813 DEPARTURE DATE: 02/20/02 OKLAHOMA CI:Y:DALLAS/FT. DALLAS/FT. :Y:SAN ANTONIO SAN ANTONIO:Y:DALLAS/FT. DALLAS/FT. :Y:OKLAHOMA CI	30399413	$318.00	
01-18-02	DELTA AIR LINES TRAVLR: SIMMS/G TICKET NUM: 0067063906820 DEPARTURE DATE: 01/27/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:BALTIMORE Name change BALTIMORE:Y:CINCINNATI CINCINNATI :Y:OKLAHOMA CI	I1K11643	423.50	
01-21-02	DELTA AIR LINES TRAVLR: GRANT/G TICKET NUM: 0067063906089 Paid on Previous invoice	D1105891		$423.50
01-21-02	DELTA AIR LINES TRAVLR: WILLIAMS/L TICKET NUM: 0067063906548	D1105892		214.00
01-22-02	AMERICAN AIRLINES TRAVLR: HILL/I TICKET NUM: 0017063906864 DEPARTURE DATE: 02/06/02 OKLAHOMA CI:Q:DALLAS/FT. DALLAS/FT. :Q:SHREVEPORT SHREVEPORT :Q:DALLAS/FT. DALLAS/FT. :Q:OKLAHOMA CI	I1L03732	362.00	
01-22-02	AMERICAN AIRLINES TRAVLR: HILL/I TICKET NUM: 0017063906864	I1L03732		362.00

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-22-02	DELTA AIR LINES TRAVLR: HANKINS/R TICKET NUM: 0067063906863 DEPARTURE DATE: 02/10/02 RENO:Q:SALT LAKE C SALT LAKE C:Q:OKLAHOMA CI	I1L09346	$207.00	
01-22-02	UNITED AIRLINES TRAVLR: BROWN/G TICKET NUM: 0167063906861 DEPARTURE DATE: 04/17/02 OKLAHOMA CI:T:DENVER DENVER:T:SAN JOSE SAN JOSE:T:DENVER DENVER:T:OKLAHOMA CI	I1L15345	212.50	
01-22-02	UNITED AIRLINES TRAVLR: HANKINS/R TICKET NUM: 0167063906862 DEPARTURE DATE: 02/06/02 OKLAHOMA CI:Y:DENVER DENVER:Y:RENO	I1L15346	202.50	
01-25-02	AMERICAN AIRLINES TRAVLR: RAMOS/E TICKET NUM: 0017063908953 DEPARTURE DATE: 02/10/02 OKLAHOMA CI:N:ST. LOUIS ST. LOUIS:N:WASHINGTON WASHINGTON :N:ST. LOUIS ST. LOUIS:N:OKLAHOMA CI	I1O04718	417.50	
01-25-02	AMERICAN AIRLINES TRAVLR: CRUTCHER/J TICKET NUM: 0017063906958 DEPARTURE DATE: 02/21/02 OKLAHOMA CI:Y:DALLAS/FT. DALLAS/FT. :Y:SAN ANTONIO SAN ANTONIO:Y:DALLAS/FT. DALLAS/FT. :Y:OKLAHOMA CI	I1O04719	218.00	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-25-02	AMERICAN AIRLINES TRAVLR: KEESEE/M TICKET NUM: 0017063906974 DEPARTURE DATE: 03/03/02 OKLAHOMA CI:N:ST. LOUIS ST. LOUIS:N:WASHINGTON WASHINGTON :N:ST. LOUIS ST. LOUIS:N:OKLAHOMA CI	I1O04720	$417.50	
01-25-02	AMERICAN AIRLINES TRAVLR: PAYNE/K TICKET NUM: 0017063906975 DEPARTURE DATE: 03/03/02 OKLAHOMA CI:N:ST. LOUIS ST. LOUIS:N:WASHINGTON WASHINGTON :N:ST. LOUIS ST. LOUIS:N:OKLAHOMA CI	I1O04721	417.50	
01-25-02	AMERICAN AIRLINES TRAVLR: PHILLIPS/C TICKET NUM: 0017063906979 DEPARTURE DATE: 02/06/02 OKLAHOMA CI:M:DALLAS/FT. DALLAS/FT. :M:SHREVEPORT SHREVEPORT :H:DALLAS/FT. DALLAS/FT. :H:OKLAHOMA CI	I1O04722	385.00	
01-25-02	AMERICAN AIRLINES TRAVLR: HILL/I TICKET NUM: 0017063906980 DEPARTURE DATE: 02/06/02 OKLAHOMA CI:M:DALLAS/FT. DALLAS/FT. :M:SHREVEPORT SHREVEPORT :H:DALLAS/FT. DALLAS/FT. :H:OKLAHOMA CI	I1O04723	385.00	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-25-02	CONTINENTAL AIR/CR MGMT TRAVLR: LORENZ/R TICKET NUM: 0057063906951 DEPARTURE DATE: 03/03/02 OKLAHOMA CI:B:HOUSTON HOUSTON:B:WASHINGTON WASHINGTON :B:HOUSTON HOUSTON:B:OKLAHOMA CI	11O07468	$417.50	
01-25-02	CONTINENTAL AIR/CR MGMT TRAVLR: DOOLEY/S TICKET NUM: 0057063906952 DEPARTURE DATE: 03/02/02 OKLAHOMA CI:B:HOUSTON HOUSTON:B:WASHINGTON WASHINGTON :B:HOUSTON HOUSTON:B:OKLAHOMA CI	11O07469	417.50	
01-25-02	CONTINENTAL AIR/CR MGMT TRAVLR: SPECTOR/M TICKET NUM: 0057063906956 DEPARTURE DATE: 02/27/02 TULSA:T:HOUSTON HOUSTON:T:NEW ORLEANS NEW ORLEANS:T:HOUSTON HOUSTON:T:TULSA	11O07470	198.00	
01-25-02	CONTINENTAL AIR/CR MGMT TRAVLR: OLMSTEAD/L TICKET NUM: 0057063906968 DEPARTURE DATE: 01/29/02 OKLAHOMA CI:T:HOUSTON HOUSTON:T:NEW ORLEANS NEW ORLEANS:T:HOUSTON HOUSTON:T:OKLAHOMA CI	11O07471	202.00	

Canceled

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-25-02	DELTA AIR LINES TRAVLR: TUCKER/L TICKET NUM: 0067063906949 DEPARTURE DATE: 02/08/02 OKLAHOMA CI:Q:DALLAS/FT. DALLAS/FT. :Q:TAMPA/ST. P TAMPA/ST. P:Q:ATLANTA ATLANTA:Q:OKLAHOMA CI	I1O11897	$408.50	
01-25-02	DELTA AIR LINES TRAVLR: OSBURN/S TICKET NUM: 0067063906950 DEPARTURE DATE: 02/09/02 TULSA:Y:ATLANTA ATLANTA:Y:TAMPA/ST. P TAMPA/ST. P:Y:ATLANTA ATLANTA:Y:TULSA	I1O11898	421.00	
01-25-02	DELTA AIR LINES TRAVLR: SLAGLE/E TICKET NUM: 0067063906954 DEPARTURE DATE: 03/11/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11899	415.50	
01-25-02	DELTA AIR LINES TRAVLR: RHOADES/E TICKET NUM: 0067063906955 DEPARTURE DATE: 03/03/02 OKLAHOMA CI:Y:CINCINNATI CINCINNATI :Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:OKLAHOMA CI Cancel	I1O11900	434.00	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT: : PERSONAL IDENTIFIER(S) REDACTED
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-25-02	DELTA AIR LINES TRAVLR: HENDERSON/P TICKET NUM: 0067063906957 DEPARTURE DATE: 02/04/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:BALTIMORE BALTIMORE:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11901	$425.00	
01-25-02	DELTA AIR LINES TRAVLR: BASHORE/S TICKET NUM: 0067063906959 DEPARTURE DATE: 02/21/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:MIAMI MIAMI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11902	424.50	
01-25-02	DELTA AIR LINES TRAVLR: VAUGHT/C TICKET NUM: 0067063906961 DEPARTURE DATE: 03/18/02 OKLAHOMA CI:Q:CINCINNATI CINCINNATI :Q:LOUISVILLE LOUISVILLE :Q:ATLANTA ATLANTA:Q:OKLAHOMA CI	I1O11903	349.50	
01-25-02	DELTA AIR LINES TRAVLR: VAUGHT/C TICKET NUM: 0067063906962 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11904	415.50	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-25-02	DELTA AIR LINES TRAVLR: VAUGHT/C TICKET NUM: 0067063906963 DEPARTURE DATE: 04/01/02 OKLAHOMA CI:Q:CINCINNATI CINCINNATI :Q:RALEIGH/DUR RALEIGH/DUR:Q:ATLANTA ATLANTA:Q:OKLAHOMA CI	I1O11905	$450.50	
01-25-02	DELTA AIR LINES TRAVLR: OLIVER MARICK TICKET NUM: 0067063906964 DEPARTURE DATE: 04/01/02 OKLAHOMA CI:Q:CINCINNATI CINCINNATI :Q:RALEIGH/DUR RALEIGH/DUR:Q:ATLANTA ATLANTA:Q:OKLAHOMA CI	I1O11906	450.50	
01-25-02	DELTA AIR LINES TRAVLR: OLIVER MARICK TICKET NUM: 0067063906965 DEPARTURE DATE: 02/28/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11907	415.50	
01-25-02	DELTA AIR LINES TRAVLR: HAWKINS/P TICKET NUM: 0067063906966 DEPARTURE DATE: 02/28/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11908	415.50	
01-25-02	DELTA AIR LINES TRAVLR: BYERLY/P TICKET NUM: 0067063906967 DEPARTURE DATE: 01/27/02 OKLAHOMA CI:H:ATLANTA ATLANTA:H:GREENSBORO/ GREENSBORO/:H:ATLANTA ATLANTA:H:OKLAHOMA CI	I1O11909	579.00	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

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DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-25-02	DELTA AIR LINES TRAVLR: DIEHL/N TICKET NUM: 0067063906969 DEPARTURE DATE: 04/10/02 OKLAHOMA CI:Y:CINCINNATI CINCINNATI :Y:BOSTON BOSTON:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11910	$439.50	
01-25-02	DELTA AIR LINES TRAVLR: SMITH EDWARDS TICKET NUM: 0067063906970 DEPARTURE DATE: 03/12/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11911	418.50	
01-25-02	DELTA AIR LINES TRAVLR: BROWN/S TICKET NUM: 0067063906971 DEPARTURE DATE: 03/12/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11912	418.50	
01-25-02	DELTA AIR LINES TRAVLR: ARCHER/P TICKET NUM: 0067063906972 DEPARTURE DATE: 03/11/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11913	415.50	
01-25-02	DELTA AIR LINES TRAVLR: PATRICK/P TICKET NUM: 0067063906973 DEPARTURE DATE: 03/01/02 OKLAHOMA CI:Y:DALLAS/FT. DALLAS/FT. :Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1O11914	431.00	

Canceled

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT: PERSONAL IDENTIFIER(S) REDACTED
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-25-02	UNITED AIRLINES TRAVLR: WILSON/A TICKET NUM: 0167063906960 DEPARTURE DATE: 02/11/02 OKLAHOMA CI:H:CHICAGO CHICAGO:H:LANSING LANSING:Q:CHICAGO CHICAGO:Q:OKLAHOMA CI	I1O18544	$473.00	
01-29-02	AMERICAN AIRLINES TRAVLR: PHILLIPS/C TICKET NUM: 0017076598771 DEPARTURE DATE: 01/29/02 OKLAHOMA CI:N:CHICAGO CHICAGO:N:WASHINGTON WASHINGTON :N:DALLAS/FT. DALLAS/FT. :N:OKLAHOMA CI	I1P03777	425.00	
01-29-02	DELTA AIR LINES TRAVLR: BAKER/K TICKET NUM: 0067076598779 DEPARTURE DATE: 03/08/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1P09730	415.50	
01-29-02	DELTA AIR LINES TRAVLR: KIRKSEY/J TICKET NUM: 0067076598780 DEPARTURE DATE: 03/08/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1P09731	415.50	
01-29-02	DELTA AIR LINES TRAVLR: WALDRON/S TICKET NUM: 0067076598781 DEPARTURE DATE: 02/11/02 TULSA:Y:ATLANTA ATLANTA:Y:TULSA	I1P09732	417.50	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

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DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
01-29-02	DELTA AIR LINES TRAVLR: HORTON/N TICKET NUM: 0067076598782 DEPARTURE DATE: 02/11/02 TULSA:Y:ATLANTA ATLANTA:Y:TULSA	I1P09733	$417.50	
02-01-02	CONTINENTAL AIR/CR MGMT TRAVLR: OLMSTEAD/L TICKET NUM: 0057063906968	D2A03555		$202.00
02-01-02	AMERICAN AIRLINES TRAVLR: MONTGOMERY/N TICKET NUM: 0017076598849 DEPARTURE DATE: 02/22/02 OKLAHOMA CI:N:DALLAS/FT. DALLAS/FT. :N:SAN DIEGO SAN DIEGO:N:DALLAS/FT. DALLAS/FT. :N:OKLAHOMA CI	I1S04358	402.00	
02-01-02	AMERICAN AIRLINES TRAVLR: LUNDY/T TICKET NUM: 0017076598850 DEPARTURE DATE: 02/22/02 OKLAHOMA CI:N:DALLAS/FT. DALLAS/FT. :N:SAN DIEGO SAN DIEGO:N:DALLAS/FT. DALLAS/FT. :N:OKLAHOMA CI	I1S04359	402.00	
02-01-02	DELTA AIR LINES TRAVLR: FINERTY/M TICKET NUM: 0067076598853 DEPARTURE DATE: 02/10/02 TULSA:Y:ATLANTA ATLANTA:Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:TULSA	I1S11088	438.50	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

PERSONAL IDENTIFICATION NUMBER

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT: PERSONAL IDENTIFICATION NUMBER
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
02-01-02	DELTA AIR LINES TRAVLR: STEPHENS STID TICKET NUM: 0067076598854 DEPARTURE DATE: 03/11/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11087	$420.50	
02-01-02	DELTA AIR LINES TRAVLR: DOUGLAS/M TICKET NUM: 0067076598855 DEPARTURE DATE: 03/12/02 OKLAHOMA CI:Y:CINCINNATI CINCINNATI :Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11088	441.00	
02-01-02	DELTA AIR LINES TRAVLR: COAKLEY/K TICKET NUM: 0067076598856 DEPARTURE DATE: 03/12/02 OKLAHOMA CI:Y:CINCINNATI CINCINNATI :Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11089	441.00	
02-01-02	DELTA AIR LINES TRAVLR: SLAGLE/E TICKET NUM: 0067076598857 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11090	420.50	
02-01-02	DELTA AIR LINES TRAVLR: MASSEY DOUGLA TICKET NUM: 0067076598858 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11091	420.50	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Diners Club International

PERSONAL IDENTIFIER(S) REDACTED

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
02-01-02	DELTA AIR LINES TRAVLR: YANCEY/T TICKET NUM: 0067076598859 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11092	$420.50	
02-01-02	DELTA AIR LINES TRAVLR: LI/P TICKET NUM: 0067076598860 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11093	420.50	
02-01-02	DELTA AIR LINES TRAVLR: LAMB/L TICKET NUM: 0067076598861 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11094	420.50	
02-01-02	DELTA AIR LINES TRAVLR: CROSS/G TICKET NUM: 0067076598862 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I1S11095	420.50	
02-01-02	UNITED AIRLINES TRAVLR: NEWPORT/J TICKET NUM: 0167076598851 DEPARTURE DATE: 02/22/02 OKLAHOMA CI:S:DENVER DENVER:S:SAN DIEGO SAN DIEGO:S:DENVER DENVER:S:OKLAHOMA CI	I1S18181	411.00	

ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE

Corporate/Government Statement

Diners Club International

[redacted]

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT: [redacted]
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
02-01-02	UNITED AIRLINES TRAVLR: HAYES/P TICKET NUM: 0167076598852 DEPARTURE DATE: 02/22/02 OKLAHOMA CI:S:DENVER DENVER:S:SAN DIEGO SAN DIEGO:S:DENVER DENVER:S:OKLAHOMA CI	I1S18182	$411.00	
02-04-02	AMERICAN AIRLINES TRAVLR: TAPSCOTT/L TICKET NUM: 0017076598898 DEPARTURE DATE: 02/06/02 OKLAHOMA CI:K:ST. LOUIS ST. LOUIS:K:LINCOLN LINCOLN:K:ST. LOUIS ST. LOUIS:K:OKLAHOMA CI	V1R03603	378.00	
02-06-02	AMERICAN AIRLINES TRAVLR: JONES/M TICKET NUM: 0017076598942 DEPARTURE DATE: 02/24/02 OKLAHOMA CI:N:ST. LOUIS ST. LOUIS:N:WASHINGTON WASHINGTON :N:OKLAHOMA CI	I2E03834	425.00	
02-06-02	DELTA AIR LINES TRAVLR: BURSAC/B TICKET NUM: 0067076598944 DEPARTURE DATE: 02/26/02 OKLAHOMA CI:Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I2E09980	420.50	
	ACCOUNT ACTIVITY CONTINUED ON NEXT PAGE			

PERSONAL IDENTIFIER(S) REDACTED

DINERS CLUB ACCOUNT ACTIVITY

ACCOUNT:
Name: OK-340 DEPT OF HEALTH
Billing Date: 02-07-02
Payment Due: 03-03-02

Date	Description	Reference Number	Charges and Other Debits	Payments and Credits
	CONTINUED FROM PREVIOUS PAGE			
02-06-02	DELTA AIR LINES TRAVLR: RHOADES/E TICKET NUM: 0087076598945 DEPARTURE DATE: 03/02/02 OKLAHOMA CI:Y:CINCINNATI CINCINNATI :Y:WASHINGTON WASHINGTON :Y:ATLANTA ATLANTA:Y:OKLAHOMA CI	I2E09981	$441.00	
02-06-02	UNITED AIRLINES TRAVLR: VINCENT/R TICKET NUM: 0187076598943 DEPARTURE DATE: 03/17/02 OKLAHOMA CI:O:CHICAGO CHICAGO:Q:LANSING LANSING:Q:CHICAGO CHICAGO:Q:OKLAHOMA CI	I2E16150	448.00	
	TOTAL FOR: PERSONAL IDENTIFIER(S) REDACTED		$29,260.50	$1,833.50

Previous Balance	- Payments	- Credits	= Past Due Balance	
$27,778.00	$9,206.75	$1,833.50	$16,637.75	
+ Late Fees	**+ New Charges**	**+ Other Debits**	**+/- Travel Advances**	**= Diners Club Balance Due**
$0.00	$29,260.50	$0.00	$0.00	$45,888.25

Hartzell, Bonnie L.

From: Hartzell, Bonnie L.
Sent: Thursday, March 07, 2002 3:23 PM
To: Lopo, Tom G.
Subject: PO Y003067 - Citicorp Diners Club - Clm#227241 bypassing

A claim in the amount of 5,099.00 was posted to this PO. One of the funding lines is 400 000235 00001 93.9940000. The amount on the claim is 835.00 but the amount in ADPICS for that funding line is 22.00.

Please correct.

Thanks.

Hartzell, Bonnie L.
From: Lopo, Tom G.
Sent: Monday, March 18, 2002 7:51 AM
To: Admin Review Team
Cc: Hartzell, Bonnie L.
Subject: FW: PO Y003067 - Citicorp Diners Club - Clm#227241 bypassing

Requesting an update please !

-----Original Message-----
From: Hartzell, Bonnie L.
Sent: Monday, March 18, 2002 7:26 AM
To: Lopo, Tom G.
Subject: FW: PO Y003067 - Citicorp Diners Club - Clm#227241 bypassing

What is the status?

-----Original Message-----
From: Hartzell, Bonnie L.
Sent: Thursday, March 07, 2002 3:23 PM
To: Lopo, Tom G.
Subject: PO Y003067 - Citicorp Diners Club - Clm#227241 bypassing

A claim in the amount of 5,099.00 was posted to this PO. One of the funding lines is 400 000235 00001 93.9940000.
The amount on the claim is 835.00 but the amount in ADPICS for that funding line is 22.00.

Please correct.

Thanks.

 OHawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		213787

FOR AGENCY USE: BT22 NW58 A-Y

CLAIM OF: NANCY C. HORTON

S.S. No. ___

PERSONAL IDENTIFIER(S) REDACTED

FOR $ 398.09 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. o

WARR NUM: 7443908
WARR DATE: 11/07/2001
CLAIM NO: 213787

IS CAR GOV. OWNED? YES ___ NO xx

LICENSE NO.

PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES xx NO ___

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000246	40002	2111	93.200 -	325.34
		2112		60.00
		2114		12.75

OSF - Audited By:

TOTAL AMOUNT $ 398.09

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue warrant in payment to said assignee.

Date:

Claimant Signature

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - LEAD

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount	
Miami-Picher-Miami	10	1	20									
Miami-Picher-Miami	10	2	20									
Miami-Oklahoma City	10	3	192		14:00							
Oklahoma City-Miami	10	4	192			21:00	1	7	~~40.00~~ 48.00	~~$50.00~~ 60	**	
Miami-Ketchum-Miami	10	8	64									
Miami-Vicinity-Miami	10	9		6								
Miami-Wyandotte-Vicinity-Afton-Miami	10	15	30	15								
Miami-Vinita-Miami	10	22	54									
Miami-Picher-Miami	10	23	20									
Miami-Vicinitty-Miami	10	24		6								
Miami-Picher-Miami-Muskogee-tulsa-Miami	10	25	272									
TOTALS			904	39			1	7	40.00	$50.00	**	$50.00
			943		943 TOTAL MILES @				34.5¢		PER MILE -	$325.34

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

*Claiming per diem in lieu of subsistence

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP. [redacted]

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI	REGISTRATION FEE (# OF MEALS INCLUDED)		
SHUTTLE:	TELEPHONE	TOLLS $12.75	
RENTAL CAR	PARKING	TOTAL MISC.	$ 12.75
OTHER LOCAL TRANSP	OTHER MISC. COSTS	TOTAL LOCAL TRANSP.	~~$325.34~~
		TOTAL AMOUNT CLAIMED	~~$388.08~~ 398.09

I, Nancy Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law; and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me 10-31 2001

My Commission expires ___ 19__

Notary Public (or Clerk or Judge)

Sum Waldron
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or

Chief, Financial Management
Agency's Approving Officer

NOV 05 2001

Title Date

Agency, Bd., or Div. Use OTTTAWA COUNTY HEALTH DEPT.
1930 NORTH ELM
MIAMI, OK 74354

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
	340		

FOR AGENCY USE

CLAIM OF: NANCY HORTON

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?
YES ____
NO XX

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?
YES XX
NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
OSF - Audited By:			TOTAL AMOUNT $	

FOR
$
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

_____
Claimant Signature

WARRANT (LOCATOR) NO

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - LEAD

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount	TOTAL PER DIEM LODGING
Miami-Quapaw-Miami	10	26	20									
Miami-Vicinity-Miami	10	29		6								
Miami-Quapaw-Miami	10	30	20									
Miami-Vicinity-Miami	10	31		6								
TOTALS					TOTAL MILES @				PER MILE =			

Oklahoma State Department of Health
Leslie M. Beitsch, MD, JD
Commissioner of Health and State Health Officer

MEMORANDUM

September 24, 2001

TO: Public Health Nursing Conference Participant

THROUGH: Stephen W. Ronck, MPH
Deputy Commissioner Community Health Services

FROM: Toni D. Frioux, MS, CNS, ARNP
Chief, Nursing Service

SUBJECT: Designated Hotel for Seventeenth Annual Public Health Nursing Conference

The Oklahoma State Department of Health is the sponsor for the objective of travel to the 17th Annual Public Health Nursing Conference on October 4–5, 2001. The conference will be held at the Biltmore Hotel, 401 South Meridian, Oklahoma City, Oklahoma. There is no registration fee.

A block of rooms has been reserved for the nights of October 3-4, 2001 for the following rate plus tax:

Singles	$59.00
Doubles	$59.00
Triples	$59.00
Quads	$59.00

Please submit this letter and a copy of the PHN Conference brochure with your travel claim for full reimbursement.

cc: Administrators, Headquarter Counties

TF:je

Board of Health
Ron L. Graves, DDS, President
John B. Carmichael, DDS
Haskell L. Evans, Jr, RPh, Vice President
Gordon H. Deckert, MD
Ron Osterhout, Secretary-Treasurer
Glen E. Diacon, Jr, MD
1000 NE 10th Street
Oklahoma City, OK 73117-1299

sessions

8:30 - 10:00
C. What to Do if They Don't Bleed on Cue
Pamela S. Miles, MD

D. Realistic Fears with TB Therapy
Jon Tillinghast, MD, MPH

E. Child Passenger Safety: 101
Shelli Stephens-Stidham; Nita Clark

10:00 – 10:30 Break

10:30 – 12:00 Small Sessions

(Supervisory Credit)

A. The Elephant in the Living Room: Dysfunctional Families
Mark Jones, MEd, LPC

B. Postpartum Adjustment Disorders and Their Effects on Breastfeeding
Crystal Stearns, RNC, MS, IBCLC

C. Tattooing, Body Piercing, and Branding
Myrna L. Armstrong, EdD, RN, FAAN

D. Diabetes Management in the Classroom – Part I
Joni Beck, PharmD, CDE; Kathy Logan, RN, MS, RD/LD, CDE; Libby Eshelman, RD/LD, CDE

E. Let's Give it a Shot
Jacque L. Brown, ARNP

12:00 - 1:30 Lunch - On Your Own

1:30 – 3:00 Small Sessions

A. Childhood Obesity
Cathy Montgomery, MS, RD/LD

B. HPV – Counseling the Client with HPV
Kristi VanNostrand, MD

Friday, October 5, 2001

sessions

1:30 – 3:00 Small Sessions

C. Diabetes Management in the Classroom – Part II
Joni Beck, PharmD, CDE; Kathy Logan, RN, MS, RD/LD, CDE; Libby Eshelman, RD/LD, CDE

D. Meth
Jerry Harris, MS

E. PNPs...Flexible, Versatile...Able to Leap Small Buildings in a Single Bound!
Pat Kelly, MEd

3:00 Adjourn
Turn in Evaluations at the Registration Desk

11.4 contact hours approved by the Colorado Nurses' Association. Oklahoma State Department of Health is approved as a provider of continuing education in nursing by the Colorado Nurses Association, which is accredited as an approver of continuing education in nursing by The American Nurses Credentialing Center's Commission on Accreditation.

Thursday, October 4, 2001

sessions

7:30 - 9:00	Registration
7:30 - 5:00	Exhibits
9:00 - 9:30	Welcome and Introductions
9:30 - 10:30	World Peace Begins at Home *Victor LaCerva, MD*
10:30 - 11:00	Break
11:00 - 12:00	Healing the Healer Within Victor LaCerva, MD
12:00 - 1:30	Lunch – On Your Own
1:30 - 3:00	Small Sessions
	A. Huffing and Puffing Julie Geddes, BS
(Supervisory Credit)	B. Cultural Sensitivities Demetrio J. Gutierrez, EdD
	C. Recognizing and Responding to Intimate Partner Violence Marcia Smith, BA
	D. Prevention Through Humor and Song Tia Shawnte (Phyllis Roller, MSSW)
	E. Increasing Awareness of Common Communicable Diseases Lauri Smithee, MES MS; Darrell Eberly, MPH
3:00 – 3:30	Break

Thursday, October 4, 2001

sessions

3:30 – 5:00	Small Sessions
(Supervisory Credit)	A. FISH - Coordinating/ Lead Nurse Session Pat Kelly, MEd
(No CE's)	B. Team Players - Roles and Responsibilities - LPN/PCA Session Ameyka Pittman, BBA
	C. What's Old and New in Newborn Metabolic Screening Julie Hankins, BSN, RN; Pam King, MPA, RN
	D. From Infant Formulas to Finger Foods Dana Bates, RD/LD, CBE
	E. Genetics and Your Practice Suzanne Davidson, MS, CGC

Friday, October 5, 2001

sessions

8:00 - 8:30	Registration
8:00 - 1:00	Poster Presentations
8:30 - 10:00	Small Sessions
	A. New Roles for PHNs for Improving Population Health Bobbie Berkowitz, PhD, RN, FAAN Larry Olmstead, BS
(Supervisory Credit)	B. Because I Said So: Positive Discipline Mark Jones, MEd, LPC

Ottawa

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		213804

FOR AGENCY USE: BT22 NW58 A-X

CLAIM OF: Susan Waldron

S.S.No. PERSONAL IDENTIFIER(S) REDACTED

FOR $ 60.72 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____ NO X	000240	40002	2111	93.200 -	60.72
LICENSE NO.					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	60.72

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to warrant in payment to said assignee.
Date: _____
Claimant Signature

WARRANT (VOUCHER) NO

BANK NUM: 7440925
BANK DATE: 11/07/2001
CLAIM NO: 213804

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 - Lead Grant

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001		Mileage Claimed		Travel Status Hour		No. of		Per Diem		Lodgi	
	Mo.	Day	Map	Vicinity	Entered	Ended	Days	Hrs	Rate	Amount	Amour	
Miami Vicinity	10	03		10								
Miami Vicinity	10	08		06								
Miami-Commerce-Miami Vicinity	10	09	08	06								
Miami-Picher-Miami Vicinity	10	10	20	04								
Miami-Picher-Miami Vicinity	10	11	20	04								
Miami-Picher Vicinity-Miami	10	12	20	10								
Miami-Commerce-Miami Vicinity	10	15	08	06								
Miami Vicinity	10	17		06								
Miami-Commerce0Miami Vicinity	10	23	08									
Miami Vicinity	100	24		06								
Miami-Welch-Miami	10	29	28									
Miami Vicinity	10	31		06								
	112		112	64								
TOTALS				176	TOTAL MILES @ .345				PER MILE =			60.72

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI	REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE	TELEPHONE TOLLS	
RENTAL CAR	PARKING	TOTAL MISC
OTHER LOCAL TRANSP.	OTHER MISC COSTS	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 60.72

I, Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of _____ County of _____

Subscribed and sworn before me 10-31-01, 19

My Commission expires _____, 19

_____
Notary Public (or Clerk or Judge)

_____
Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Chief, Financial Management
Agency's Approving Officer

NOV 05 2001
Date

OTTAWA COUNTY HEALTH DEPT.
Title
1930 NORTH ELM
Agency, Bd., or Div MIAMI, OKLAHOMA 74354

Ottawa

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		217115

FOR AGENCY USE: BT22 NW58 A-X

CLAIM OF: Nancy Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	000240	40002	2111	93.200	48.99
NO X					
LICENSE NO.					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	48.99

FOR $ 48.99
AGAINST
Agency, Board, Comm., Dept: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
_____
Claimant Signature

WARRANT

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19__ Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
Miami-picher-Miami	11	1	20								
Miami-Picher-Miami	11	2	20								
Miami-Picher-Miami	11	5	20								
Miami-Afton-Miami	11	6	30								
Miami-Picher-Miami	11	7	20								
Miami-Vicinity	11	9		4							
Miami-Commerce-Miami	11	9	8								
Miami-Picher-Miami	11	30	20								
TOTALS			138	4							
			142		TOTAL MILES @		.345		PER MILE =		48.99

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 48.99

I, Nancy Horton, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me 11-30- 2001

My Commission expires _____, 19__

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State Travel Reimbursement Act or _____

Chief Financial Management
Agency Approving Officer

Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354
918-540-2481

Title

Date

Agency, Bd., or Div. Use

Ottawa

OSF Form 19
(Revised 7/96)
STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		220886

FOR AGENCY USE: BT22 NW58 A-X

CLAIM OF: Nancy C. Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	000240	40002	211	93.200 -	51.06
NO X					
LICENSE NO.					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	51.06

FOR $ 51.06
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____

and authorize the State Treasurer to warrant in payment to said assignee

Date: _____

Claimant Signature

WARR DATE: 01/11/2002 WARR NUM: 7659272 CLAIM NO: 220886

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2001 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Loc Am
Miami-Picher-Vic-Miami	12	5	20	10							
Miami-Picher-Miami	12	6	20	10							
Miami-Picher-Miami	12	13	20								
Miami-Picher-Miami	12	17	20	3							
Miami-Picher-Miami	12	19	20								
Miami-picher-Miami	12	20	20	3							
Miami-Miami	12	28		2							
TOTALS			148	28			TOTAL MILES @ .345		PER MILE =		51.06

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 51.06

I, Nancy C. Horton, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me January 2, 2002

My Commission expires _____ 19 _____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State.

State Travel Reimbursement Act or _____

Chief, Financial Management

Agency's Approving Officer

1-8-02
Date

Title

Agency, Bd., or Div Use

Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354
918-540-2481

OSF Form 19
(Revised 7/95)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		22434b

FOR AGENCY USE: BT22 NW58 A-X

CLAIM OF: OTTAWA 12
Remedios Tirres

S.S. No: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED?	ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
YES ____	00040	40002	2111	93.70 -	40.52
NO X			2114		8.00
LICENSE NO.					
PERSONAL IDENTIFIER(S) REDACTED					
IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE?					
YES X					
NO ____					
	OSF - Audited By:			TOTAL AMOUNT $	48.52

FOR $ 48.52
AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer warrant in payment to said assign
Date: _____
_____ Claimant Signature

WARRANT (VOUCHER) NO

BANK CODE: 72077992
BANK NUM: 2202002
CHECK NO: 224340

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	OJJDP 391 Lead Agency

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)

Date 19		Mileage Claimed		Travel Status Hour		No. of		Per Diem		ALLOWABLE ITEMIZING
Mo	Day	Map	Vicinity	Entered	Ended	Days	Hrs.	Rate	Amount	
Miami-Claremore-Miami	1	15	124							
Miami-Claremore-Miami	1	18	124							
TOTALS			248							
			248	TOTAL MILES @ .365				PER MILE =		90.52

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI	REGISTRATION FEE (# OF MEALS INCLUDED)		
SHUTTLE	TELEPHONE	TOLLS 8.00	
RENTAL CAR	PARKING	TOTAL MISC	8.00
OTHER LOCAL TRANSP.	OTHER MISC COSTS	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	98.52

I, Remedios Tirres, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Remedios Tirres
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me January 31, 2002

My Commission expires _____, 19____

_____ Notary Public (or Clerk or Judge)

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or _____

Agency's Approving Official Financial Management

Title

Agency, Bd., or Div. Use

Date 2-7-02

Approving Supervisor's Signature

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		224347

FOR AGENCY USE: BT22 NW58 A-X

CLAIM OF: Nancy C. Horton

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO x LICENSE NO.

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000240	40002	2111	93.200	23.00

PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES x NO ____

OSF - Audited By:

TOTAL AMOUNT $ 23.00

FOR $ 23.00 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to ____
and authorize the State Treasurer to warrant in payment to said assignee
Date: ____
Claimant Signature

WARRANT (VOUCHER) NO

WARR NUM: 7767992
WARR DATE: 02/12/2002
CLAIM NO: 224347

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead Conducted Parkings

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 1992 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lo Am
Miami-~~Miami~~ Vicinity	1	8		3							
Miami-Picher-Miami	1	21	20								
Miami-Quapaw-Miami	1	24	20								
Miami-Picher-Miami	1	29	20								
TOTALS			60	3							
			63		TOTAL MILES @ .365				PER MILE =		23.00

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED)	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.
		TOTAL AMOUNT CLAIMED 23.00

I, Nancy C. Horton the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of OKLAHOMA County of OTTAWA

Subscribed and sworn before me January 31, 1992

My Commission expires ____ 19 ____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or ____

Agency's Approving Officer

Chief Financial Management

Title Date 2-7-02

Agency, Bd., or Div. Use

Ottawa

OSF Form 19 (Revised 7/96)
STATE OF OKLAHOMA TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		224847

FOR AGENCY USE: BT22 NW58 A-X

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000740	40002	2111	93.200 -	252.58
		2114		9.50

OSF - Audited By:

TOTAL AMOUNT $262.08

FOR $ 262.08 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 779591
WARR DATE: 02/14/2002
CLAIM NUM: 224847

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2002 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodgir Amour
Miami-Vicinity-Miami	1	8		10							
Miami-Picher-Miami	1	9	20								
Miami-Picher-Miami	1	9	20								
Miami-Claremore-Miami	1	15	124	4							
Miami-Claremore-Miami	1	16	124	4							
Miami-Claremore-Miami	1	17	124	4							
Miami-Picher-Miami	1	21	20								
Miami-Tulsa-Miami	1	23	178	6							
Miami-Vinita-Miami	1	25	54								
TOTALS			664	28							
			692		TOTAL MILES @	.365			PER MILE		252.58

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ___ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS		
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:	TELEPHONE:	TOLLS: 9.50	
RENTAL CAR:	PARKING:	TOTAL MISC.	9.50
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	
		TOTAL AMOUNT CLAIMED	262.08

I, Susan Waldron, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me February 1, 2002

My Commission expires _____, 19____

_____
Notary Public (or Clerk or Judge)

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or _____

Chief, Financial Management
Agency's Approving Officer

Title Date

Agency, Bd., or Div. Use

_____
Approving Supervisor's Signature

2.19.02

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		226848

FOR AGENCY USE: BT 23 NW58 A-X

CLAIM OF: Remedios Tirres

S.S. No. PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO x

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES x NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00240	4002	211	93.200	23.36

OSF - Audited By:

TOTAL AMOUNT $ 23.36

FOR $ 23.36 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to i[illegible] warrant in payment to said assignee.

Date:

Claimant Signature

WARRANT (LOCATOR) NO.

WARR NUM: 7846123
WARR DATE: 03/06/2002
CLAIM NO: 226848

OFFICIAL DUTY STATION: [illegible]

NATURE OF OFFICIAL BUSINESS: 391 Lead Survey Conducted

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 19__ Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	2	1		35							
Miami-Vicinity-Miami-	2	2		25							
Miami-Vicinity-Miami-	2	7		4							
TOTALS				64							

64 TOTAL MILES @ .365 PER MILE = 23.36

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

AGENCY DIRECT PURCHASE ____ (x) TOTAL PUBLIC TRANSP.

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS	
TAXI:	REGISTRATION FEE (# OF MEALS INCLUDED):	
SHUTTLE:	TELEPHONE: TOLLS:	
RENTAL CAR:	PARKING:	TOTAL MISC.
OTHER LOCAL TRANSP.	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.

TOTAL AMOUNT CLAIMED 23.36

I, Remedios Tirres the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Remedios Tirres
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me February 28, 2002

My Commission expires ____ 19__

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

MAR 01 2002

State Travel Reimbursement Act or

Agency's Approving Officer

Title

Agency, Bd., or Div. Use

Ottawa County Health Dept.
Chief, Financial Management
1070 North Elm
Miami, Oklahoma 74354
918-540-2481

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340		22693

FOR AGENCY USE: BT 22 NW 58 AK

CLAIM OF: Nancy C. Horton

S.S. No.: PERSONAL IDENTIFIER(S) REDACTED

IS CAR GOV. OWNED? YES ____ NO X LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ____

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
00140		2121	93.283.000	66.40
		2123		133.00
		2125		133.00
		2126		318.00
		2134	1	3.55
		2111		72.27

OSF - Audited By:

TOTAL AMOUNT $ 547.52

FOR $ 547.52 AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue warrant in payment to said assignee.
Date: _____
Claimant Signature

WARR NUM: 7846151 WARR DATE: 03/06/2002 CLAIM NO: 2122939

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead SURVEYS, AT 72.00 and PAVE

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2002 Mo	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-Miami	2	1		38							
Miami-Vicinity-Miami	2	2		38							
Miami-Quapaw-Vicinity-Miami	2	5	20	12							
Miami- Afton-Vicinity-Miami	2	8	30	58	0800	1655					
Miami-Vicinity-Fairland-Tulsa	2	11	89		0400						
-Atlanta-	2	12									
-Atlanta-	2	13									
-Atlanta-Tulsa-Fairland-Miami	2	14	89	4		2000	3	16	38.00	142.50	460.56
-Vicinity-Miami-											
Miami-Picher-Miami	2	18	20								
Miami-Vicinity-Miami	2	19		6							
Miami-Vicinity-Miami	2	7		6							
TOTALS			384								

TOTAL MILES @ .365 PER MILE = 140.16

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED 3.50

AGENCY DIRECT PURCHASE X (x) TOTAL PUBLIC TRANSP. 3.50

ITEMIZED LOCAL TRANSPORTATION		ITEMIZED MISCELLANEOUS COSTS		
TAXI:		REGISTRATION FEE (# OF MEALS INCLUDED):		
SHUTTLE:		TELEPHONE:	TOLLS: 4.30	
RENTAL CAR:		PARKING:	TOTAL MISC.	4.30
OTHER LOCAL TRANSP.	3.50	OTHER MISC. COSTS:	TOTAL LOCAL TRANSP.	7.80
			TOTAL AMOUNT CLAIMED	608.52

I, Nancy C. Horton, the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Nancy C. Horton
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me February 27, 2002

My Commission expires _____, 19____

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or _____

R. C. Lee
Agency's Approving Officer

Chief, Financial Management
Title

Agency, Bd., or Div. Use

Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354
918-540-2481

MAR 08 2002

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Call Your Travel Agent or 1-800-HILTONS

We look forward to serving you again soon.

I CERTIFY THIS AS AN ORIGINAL
C. Horton
3-4-02

Hilton
Atlanta

255 Courtland Street, NE
Atlanta, GA 30303
PH: (404) 659-2000 FAX: (404) 221-6368
http://www.hilton.com

MC

IN	OUT	FOLIO
02/11	02/14/02	630285

01/05

NAME: HORTON, NANCY

RATE: HHE000 93.00

Page 1 A

ADDRESS: PERSONAL INFORMATION REDACTED

ROOM 609

JCL

TRAVEL AGENCY

DATE	DESCRIPTION	ID	CREDITS	CHARGES	CREDITS	BALANCE
02/11/02	ROOM RATE	XAP	609	93.00		
02/11/02	SALES TAX	XAP	609	6.51		
02/11/02	OCCUPANCY TAX	XAP	609	6.51		
02/12/02	LE CAFE	XAQ	5646	13.97		
02/12/02	ROOM RATE	XAP	609	93.00		
02/12/02	SALES TAX	XAP	609	6.51		
02/12/02	OCCUPANCY TAX	XAP	609	6.51		
02/13/02	LE CAFE	XAQ	5794	14.63		
02/13/02	ROOM RATE	XAP	609	93.00		
02/13/02	SALES TAX	XAP	609	6.51		
02/13/02	OCCUPANCY TAX	XAP	609	6.51		
02/14/02	MASTERCARD	JCL			346.66	
02/14/02	C/O TIME 11:57	JCL		0.00	-28.60	
EFFECTIVE BALANCE:					318.06	0.00

Checked In 11:47 AM by JCL

Checked Out 11:57 AM by JCL

GUEST

FIRM ADDRESS

RATES DO NOT INCLUDE APPLICABLE SALES, OCCUPANCY OR OTHER TAXES

TRANSFER TO CREDIT LEDGER

I AGREE THAT MY LIABILITY FOR THIS BILL IS NOT WAIVED AND AGREE TO BE HELD PERSONALLY LIABLE IN THE EVENT THAT THE INDICATED PERSON, COMPANY OR ASSOCIATION FAILS TO PAY FOR ANY PART OR THE FULL AMOUNT OF THESE CHARGES.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control
and Prevention (CDC)
Mailstop E-25
Atlanta, Georgia 30333
(404) 498-1420

December 17, 2001

Ms. Susan Waldron
Health Educator
Ottawa County Health Department
1930 N. Elm
Miami, OK 74354

Dear Ms. Waldron:

On behalf of the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Environmental Protection Agency (EPA), U. S. Housing and Urban Development (HUD), the Agency for Toxic Substances and Disease Registry (ATSDR), I am pleased that you have agreed to speak at the grantee's National Lead Health Education Conference. Approximately 250 lead health educators and representatives of state and local childhood lead poisoning prevention programs (CLPPPs) are expected to attend. The purpose of the conference is to improve the effectiveness of health education activities in CLPPPs nationwide. The theme of the conference if **"The Mission Is Possible: Lead-Safe Kids."**

The following is information about the session(s) for which you will be presenting or moderating:

Tuesday 2/12/02: 1:30 - 3:00 pm: Program Development and Implementation
Thursday 2/14/02: 10:00 – 11:15 am
A-1/F-3: Successful Program Development and Implementation (two concurrents A-1/F-3)
Format: Panel
Session Description:

Development and implementation are two vital first steps that can propel a lead health education program to success. In this session, speakers will describe the processes they used to develop and implement their local lead health education programs, highlighting aspects that worked well and pitfalls to be avoided. Based on sound program development and implementation principles, components to be addressed include: strategic program planning; use of surveillance and other data; theory-based educational interventions; collaborating and coordinating; and program evaluation.

The conference will be held at the **Hilton Atlanta, 255 Courtland Street, Atlanta, Georgia,** and will begin on Tuesday, February 12, 2002 at 8:30 a.m. All sessions will conclude on Thursday, February 14, 2002 at 12:30 p.m. Unless previously discussed with you, we are requesting that all speakers who are grantees make their own hotel and travel arrangements. The Hilton Atlanta room rates are $93.00 plus tax single occupancy or $118 plus tax double occupancy per night. **Hotel reservations can be made by calling toll free 1-(800)-445-8667, deadline January 4, 2002.** Please identify yourself as a participant of the CDC Lead Health Education Conference to secure the group rate

PROCUREMENT DIVISION

PROCUREMENT DIVISION

2002 JAN 25 P 3:09

2002 JAN 22 P 3:54

OKLAHOMA STATE DEPARTMENT OF HEALTH

INTERSTATE TRAVEL REQUEST/AUTHORIZATION

DIVISION: Community Health Services \ Ottawa County Health Dept.

APPLICANT: Nancy C. Horton POSITION (Title): PHN II - Program Grant Consultant

NATURE OF TRIP: 2002 National Lead Health Conference

The Mission is Possible: Lead Safe Kids (Name) Feb 11-14 (Date) Atlanta, Georgia (Location)

JUSTIFICATION FOR TRIP: Breakout Sessions presentations for 2 separate sessions on successful Lead Poisoning Prevention Programs - funding Provided through ATSDR grant for Ottawa County Lead Project

DEPARTURE: 2-11-02 DATE OF RETURN: 2-14-02

MODE OF TRANSPORTATION (Private – Public): Airline Ticket: V Car: _____ Bus: _____
(If traveling by car a cost comparison must be attached)

DURATION OF TRIP WILL INCLUDE: 4 DAYS AT MEETING AND 2 DAYS ENROUTE

TOTAL NUMBER OF DAYS: 4

ESTIMATED COST: $ ~~345.00~~ 417.50 (Travel) $ 152.00 (Per Diem) $ 300 93/night (Other) $ ~~797.00~~ 869.50 (Total)

APPROVED

Nichols SW
(Division Director/Service Chief)

FINANCIAL MANAGEMENT

Attendee Lead Grant

FUNDING: 400BT22 (Fund) 000235NW07 (Account) 35005 (Sub-Activity) 93.200 (CFDA #)

Reimbursed by _____
(Used when non-OSDH resources are covering the entire cost of the meeting)

JANUARY 01/29/02
(Financial Management Approval)

APPROVAL AND TRAVEL AUTHORIZATION

The individual named is authorized to perform official travel as indicated:

~~Stephen W. Lynch~~ ~~Deputy Comm~~ 1-17-02
Name Title (Date)
(Executive Director/Deputy Commissioner/Commissioner)

OSDH Form No. 81
(Rev 10/2000)

Y003067-OT

OKLAHOMA STATE DEPARTMENT OF HEALTH
INTERSTATE TRAVEL REQUEST/AUTHORIZATION

DIVISION: Community Health Services \ Ottawa County Health Dep.

APPLICANT: Nancy C. Horton POSITION (Title): PHN II - Program Grant Consultan

NATURE OF TRIP: 2002 National Lead Health Conference

The Mission is Possible: Lead Safe Kids (Name) Feb. 11-14 (Date) Atlanta, Georgia (Location)

JUSTIFICATION FOR TRIP: Breakout sessions presentations for 2 separate sessions on Successful Lead Poisoning Prevention Program - funding provided through NIOSH grant for Ottawa County Lead Project

DEPARTURE: 2-11-02 DATE OF RETURN: 2-14-02

MODE OF TRANSPORTATION (Private - Public): Airline Ticket: X Car: ___ Bus: ___
(If traveling by car a cost comparison must be attached)

DURATION OF TRIP WILL INCLUDE: 3 DAYS AT MEETING AND 2 DAYS ENROUTE

TOTAL NUMBER OF DAYS: 4

ESTIMATED COST: $ $345.00 (Travel), $ 152.00 (Per Diem), $ 93/night 300 (Other), $ 797.00 (Total)

APPROVED

(Division Director/Service Chief)

FINANCIAL MANAGEMENT

FUNDING: _____ (Fund) _____ (Account) _____ (Sub-Activity) _____ (CFDA #)

Reimbursed by _____
(Used when non-OSDH resources are covering the entire cost of the meeting)

_____
(Financial Management Approval)

APPROVAL AND TRAVEL AUTHORIZATION

The individual named is authorized to perform official travel as indicated:

_____ _____ _____
Name Title (Date)
(Executive Director/Deputy Commissioner/Commissioner)

OSDH Form No. 81
(Rev 10/2000)

TRAVEL AGENTS INCORPORATED
9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: 66 ITINERARY/INVOICE NO. 0059022 DATE: 29 JAN 02
CUSTOMER NBR: 0000012057 HDFKGH PAGE: 01

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK, 73117
DLVR TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVSION
ORDERED BY ANGIE 271 1789
PURCHASE ORDER NUMBER Y0030670T
FOR: HORTON/NANCY

DELTA TICKETLESS CONFIRMATION NBR VKOALR

11 FEB 02 - MONDAY
AIR DELTA AIR LINES INC FLT:1618 COACH
LV TULSA 705A EQP: BOEING 737-800
01HR 50MIN
AR ATLANTA 955A NON-STOP
ARRIVE: SOUTH TERMINAL REF: VKOALR
HORTON/NANCY SEAT-12C

14 FEB 02 - THURSDAY
AIR DELTA AIR LINES INC FLT:245 COACH
LV ATLANTA 510P EQP: BOEING 737-800
DEPART: SOUTH TERMINAL 02HR 01MIN
AR TULSA 611P NON-STOP
REF: VKOALR
HORTON/NANCY SEAT-19D

AIR TICKET DL7076598782 HORTON NANCY
ELEC TKT BILLED TO PERSONAL IDENTIFIER(S) REDACTED 417.50*

SUB TOTAL 417.50
NET CC BILLING 417.50*

TOTAL AMOUNT DUE 0.00

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES

Due 0-94

AG-66

Passes, Fare & Phone Information

MARTA is the most cost-effective way to travel in Atlanta — and the most convenient, with a wide variety of fares and passes available. Regular riders can choose from several TransCard, Half Fare or individual token rates, while out-of-towners can utilize a specially-priced visitor's transit pass. It's good for unlimited travel aboard the rail and bus system.

The regular fare is $1.75 for transportation throughout the system and may be paid with tokens or exact change. Tokens can be purchased individually or in rolls of 10 at the entrances to MARTA stations or at all RideStores.

Flying into town? MARTA connects into the terminal building at Atlanta Hartsfield International Airport. Rail cars are equipped with ample baggage space. Trains depart every 8 to 10 minutes.

- A single $1.75 fare covers one-way bus or train trips, including transfers. Bus riders may drop tokens or exact cash into the fare box near the driver, or may slide their weekly or monthly TransCard through the electronic card reader. Ask the driver for a transfer ticket when you board.
- Train riders may use tokens or exact change (coins only-no pennies), bus-to-rail transfer tickets, or weekly or monthly TransCards to unlock turnstiles, which lead to the boarding platforms. Token machines are located outside all station entrances.
- Buses generally run from 5 a.m. to 1 a.m., Monday through Friday, and from 6 a.m. until 1 a.m. on weekends and holidays. Individual bus routes vary. Call Customer Information at (404) 848-4711 for details.

TRANSCARDS

Monthly TransCard	$52.50
Weekly TransCard	$13
Half-Fare with Half-Fare Card	$.85
Out-of-District Half-Fare	$1.25

Permits are issued to persons 65 or older, holders of Medicare cards or persons with certain disabilities. Call the Half-Fare Office at (404) 848-5112 for details.

TOKENS

10 Tokens	$17.50
Pack of 20 one-way passes	$30

(Only at Airport and Five Points.)

VISITOR'S PASS

Orders are accepted only for groups of 15 or more. Order at least 20 business days in advance.

1-day Visitor's Pass	$ 7
2-day Visitor's Pass	$ 8
3-day Visitor's Pass	$ 9
4-day Visitor's Pass	$10
5-day Visitor's Pass	$11
6-day Visitor's Pass	$12
7-day Visitor's Pass	$13

For each additional day add $2.
Call (404) 848-5501.

WEEKEND PASS

Pre-purchase during the week at any MARTA RideStore.

Friday through Sunday $9

STUDENT TRANSCARD

See school administrator $10

UNIVERSITY PASS

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$37 monthly TransCard is sold through participating schools. Check with your student affairs office.

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Call (404) 848-5067.

Note: Transfers are free between MARTA and Cobb Community Transit (CCT), which serves Cobb County. For CCT route and schedule information, contact (770) 427-4444.

System-wide rail service operates seven days a week, 5 a.m. until 1 a.m.

continued on page 14

All guest speakers who will be traveled by one of the host agencies (not through your existing lead grants), please follow the directions below regarding your travel arrangements:

Agency Guest Speaker	Contact	Special Note
CDC	Sato Travel at (404) 633-0520/flight reservations Hilton Hotel at 1-800-445-8667 CDC travel contact: Latash Scruggs-Hill (404) 498-1429, zzv9@cdc.gov	Identify yourself as a traveler for the Lead Poisoning Prevention Branch, Executive Park, Building 6 ****Contract carriers must be utilized, no exceptions allowed.**
EPA	Darlene Watford: (202) 260-3989 Watford.Darlene@.epa.gov Hilton Hotel at 1-800-445-8667	Ms. Watford will provide you with further travel guidance.
HUD	Staci Gilliam: (202)-755-1785 x 110 Staci_N._Gilliam@HUD.GOV Hilton Hotel at 1-800-445-8667	Ms. Gilliam will provide you with further travel guidance

In preparation for the conference, please complete the enclosed speaker/moderator registration form and fax it to Joy Gulliksen at (404) 498-1444 by January 4, 2002. If you have any questions, or need additional information, please call Ms. Gulliksen (404) 498-1432 or e-mail jpg4@cdc.gov.

Please note: Speakers will be responsible for providing copies and handouts (approximately 75 copies for breakout sessions and 250 for plenary sessions). These materials should be mailed to the hotel at the following address:

Hilton Atlanta
Attn: Joy Gulliksen
255 Courtland Street
Atlanta, GA 30303

The hotel has limited storage space. Shipments are to arrive no earlier than February 9, 2002. Should the hotel need to return boxes for participants after the conference, the participant will be responsible for shipping fee, plus the handling charge of 50 cents per pound. All boxes should be marked--Hold for CDC Lead Health Education Conference.

We value your contribution and appreciate you taking time from your busy schedule to participate in this important event. We look forward to a successful conference.

Sincerely,

Gary P. Noonan, MPA, Acting Chief
Lead Poisoning Prevention Branch

Enclosure

OSF Form 19
(Revised 7/96)

STATE OF OKLAHOMA
TRAVEL VOUCHER

FUND	AGENCY	ORDER NO.	CLAIM NO.
405	340		228067

FOR AGENCY USE: BT22 MW 58 A X

CLAIM OF: Susan Waldron

S.S. No. PERSONAL IDENTIFIER(S) ~~REDACTED~~

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
~~[illegible]~~	~~35005~~		93700000	
005240	4002	2111		144.18
		~~2121~~		
		2123		142.50
		2124		3.50
		~~2125~~		
		2126		318.06
		2114		5.00

IS CAR GOV. OWNED? YES ___ NO X

LICENSE NO. PERSONAL IDENTIFIER(S) REDACTED

IS CLAIMANT A STATE OFFICIAL OR EMPLOYEE? YES X NO ___

OSF - Audited By:

TOTAL AMOUNT $ 663.24

FOR $ 663.24 AGAINST

Agency, Board, Comm., Dept.: Okla. State De

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to is warrant in payment to said assignee.

Date:

Claimant Signature

WARR DATE: 03\18\2002
WARR NUM: 7886918
CLAIM NO: 228067

OFFICIAL DUTY STATION	NATURE OF OFFICIAL BUSINESS
Miami	391 Lead (Conference) ATTENDED

Show point travel status began, each point visited and the point travel status ended. (Vicinity only travel should show general geographical area, e.g., Tulsa Vicinity)	Date 2002 Mo.	Day	Mileage Claimed Map	Vicinity	Travel Status Hour Entered	Ended	No. of Days	Hrs.	Per Diem Rate	Amount	Lodging Amount
Miami-Vicinity-~~Miami~~	2	2		38							
Fairland-Grove-Vic-Miami	2	4	38	10							
Miami-Tulsa-Vic-Miami	2	5	178	16							
Fairland-Grove-Vic-Fairland	2	8	28	10							
Fairland-Tulsa-Atlanta *	2	11	*		0420						
-Atlanta-	2	12									
-Atlanta-	2	13									
-Atlanta-Tulsa-Fairland	2	14	*			0920	3	16	38.00	142.50	[illegible]
Miami-Picher-Miami	2	18	20			2120		17			
Miami-Vicinity-~~Miami~~	2	21		10							
Miami-Tulsa-Vic-Miami	2	22	178	16							
					40						
TOTALS			432	100			3	17		142.50	318.06
			532		TOTAL MILES @ .365					PER MILE =	194.18

Rode w/ Nancy Horton

CLUES IN A
LE
ATLANTA LODGING
93.00 [illegible]

MODE OF PUBLIC TRANSPORTATION & AMOUNT CLAIMED

~~* Airline ticket purchased by OSDH [illegible]~~

AGENCY DIRECT PURCHASE X (x) TOTAL PUBLIC TRANSP. ~~3.50~~

ITEMIZED LOCAL TRANSPORTATION	ITEMIZED MISCELLANEOUS COSTS
TAXI	REGISTRATION FEE (# OF MEALS INCLUDED): NONE
SHUTTLE 3.50	TELEPHONE TOLLS 5.00 2/5 - 2/22
RENTAL CAR	PARKING TOTAL MISC. 3.50
OTHER LOCAL TRANSP.	OTHER MISC COSTS: TOTAL LOCAL TRANSP. 3.00
	TOTAL AMOUNT CLAIMED 663.24

I, Susan Waldron the undersigned, upon oath, do depose and say that I have full knowledge of the above and foregoing account, that said account is just, correct, due and according to law, and that the amount claimed after allowing all just credits, is now due and wholly unpaid, and that I am duly authorized to make this affidavit.

Susan Waldron
Claimant Signature

State of Oklahoma County of Ottawa

Subscribed and sworn before me February 27, 2002

My Commission expires ____ 19__

Notary Public (or Clerk or Judge)

Approving Supervisor's Signature

I hereby approve this claim for payment and certify it complies with the travel laws of the State

State Travel Reimbursement Act or MAR 13 2002

Agency's Approving Officer

Chief, Financial Management
Ottawa County Health Dept.
1930 North Elm
Miami, Oklahoma 74354
918-540-2481

Title

Agency, Bd., or Div. Use

We Hope You Enjoyed Your Stay !

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We look forward to serving you again soon.

Hilton
Atlanta

255 Courtland Street, NE
Atlanta, GA 30303
PH: (404) 659-2000 FAX: (404) 221-6368
http://www.hilton.com

05/02

NAME: WALDRON, SUSAN

IN 02/11 OUT 02/14/02 FOLIO 628698

RATE HHE000 93.00

Page 1 A

ROOM 610

ADDRESS: PERSONAL INFORMATION REDACTED

PMSHHCPMSHH0207-045[illegible]

TRAVELCLY

DATE	DESCRIPTION	ID	REF. NO	CHARGES	CREDITS	BALANCE
02/11/02	ROOM RATE	XAP	610	93.00		
02/11/02	SALES TAX	XAP	610	6.51		
02/11/02	OCCUPANCY TAX	XAP	610	6.51		
~~02/12/02~~	~~LE CAFE~~	~~XAQ~~	~~5451~~	~~17.00~~		
~~02/12/02~~	~~LE CAFE~~	~~XAQ~~	~~5647~~	~~17.00~~		
02/12/02	ROOM RATE	XAP	610	93.00		
02/12/02	SALES TAX	XAP	610	6.51		
02/12/02	OCCUPANCY TAX	XAP	610	6.51		
~~02/13/02~~	~~VID-COM~~	~~XQQ~~	~~19.50~~	~~10.69~~		
02/13/02	ROOM RATE	XAP	610	93.00		
02/13/02	SALES TAX	XAP	610	6.51		
02/13/02	OCCUPANCY TAX	XAP	610	6.51		
02/14/02	AMER. EXPRESS	JCL			362.75	
02/14/02	C/O TIME 11:55	JCL		0.00	-44.69	
					$ 318.06	
EFFECTIVE BALANCE:						0.00

Checked In 11:46 AM by JCL

Checked Out 11:55 AM by JCL

RATES DO NOT INCLUDE APPLICABLE SALES, OCCUPANCY OR OTHER TAXES

TRANSFER TO CREDIT LEDGER

I AGREE THAT MY LIABILITY FOR THIS BILL IS NOT WAIVED AND AGREE TO BE HELD PERSONALLY LIABLE IN THE EVENT THAT THE INDICATED PERSON, COMPANY OR ASSOCIATION FAILS TO PAY FOR ANY PART OR THE FULL AMOUNT OF THESE CHARGES.

GUEST

FIRM ADDRESS

CITY STATE ZIP

GUEST SIGNATURE

2002 National Lead Health Education Conference
Agenda At-A-Glance
THE MISSION IS POSSIBLE: LEAD-SAFE KIDS

Monday, 2/11/2002	**4:00 - 7:00 pm**	**Registration – Ongoing throughout Conference – Pre-function Area**				
	4:00 - 7:00 pm	**Pre-conference Workshop - Logic Modeling – Newton**				
	5:00 - 6:30 pm	**Pre-conference Meeting (EPA Tribal Grantees) – Forsyth**				
Tuesday, 2/12/2002	**8:00 - 10:30 am**	**Registration – Pre-function Area**				
	8:30 - 10:00 am	**Plenary I - Welcome & Keynote – Ballroom West**				
	10:00 - 10:30 am	**BREAK**				
	10:30 - 12:00 pm	**Plenary II - Program Development – Ballroom West**				
	12:00 - 1:30 pm	**LUNCH (on your own)**				
	1:30 - 3:00 pm	**Concurrent A**	A-1 Successful Program Development and Implementation – Forsyth	A-2 Primary Prevention Outreach Strategies – Rockdale	A-3 School-Based Lead Education – Newton	A-4 Surveillance & GIS Mapping for Health Ed Programs – Fayette
	3:00 - 3:30 pm	**BREAK**				
	3:30 - 4:45 pm	**Concurrent B**	**B-1** Leadership & Roles of Health Educators – Rockdale	**B-2** Working with Medicaid -Fayette	**B-3** Coalitions in Lead Education – Forsyth	**B-4** Engaging Community Leaders – Newton
	4:45 - 5:30 pm	**Exhibits – Cherokee/Jackson**				
	5:30 - 6:30 pm	**Welcome Reception – Salons A & B**				
Wednesday, 2/13/2002	**8:30 - 9:45 am**	**Plenary III - Educating Special Populations: Providers – Ballroom West**				
	9:45 - 10:15 am	**BREAK**				
	10:15 - 11:30 am	**Concurrent C**	C-1 Provider Outreach & Education – Forsyth	C-2 Reaching Multicultural Audiences – Newton	C-3 Reaching Special Populations – Rockdale	C-4 Reaching Parents Groups – Fayette
	11:30 - 1:00 pm	**LUNCH (on your own)**				
	1:00 - 2:30 pm	**Plenary IV - Program Evaluation – Ballroom West**				
	2:30 - 3:00 pm	**BREAK**				
	3:00 - 4:30 pm	**Concurrent D**	**D-1** Provider Outreach & Evaluation – Newton	**D-2** Applying Research Evaluation Methods – Forsyth	**D-3** Case Studies in Evaluation – Fayette	**D-4** Community Outreach Campaigns – Rockdale
	4:30 - 5:30 pm	**Exhibits – Cherokee/Jackson**				
Thursday, 2/14/2002	**8:30 - 9:45 am**	**Concurrent E**	E-1 Community Partnerships – Newton	**E-2** Training Staff in Lead-Safe Work Practices – Fayette	**E-3** Reaching Multicultural Audiences – Rockdale	**E-4** Community Outreach Campaigns – Forsyth
	9:45 - 10:00 am	**BREAK**				
	10:00 - 11:15 am	**Concurrent F**	F-1 Public Interest in Lead-Safe Homes – Fayette	F-2 Reaching Special Populations – Newton	**F-3** Successful Program Development & Implementation – Rockdale	
	11:15 - 11:30 am	**BREAK**				
	11:30 - 12:00pm	**Plenary V - Closing Remarks – Ballroom East**				

Leave from Tulsa

PROCUREMENT DIVISION PROCUREMENT DIVISION

OKLAHOMA STATE DEPARTMENT OF HEALTH
INTERSTATE TRAVEL REQUEST/AUTHORIZATION

2002 JAN 22 P 2002 JAN 25 P 3:09

DIVISION: Ottawa County Health Dept. / Community Health Services

APPLICANT: Susan Waldron POSITION (Title): Health Educator

NATURE OF TRIP: 2002 National Lead Health Education Conference

The Mission Is Possible: Lead Safe Kids (Name) 2/11/02-2/14/02 (Date) Atlanta, GA (Location)

JUSTIFICATION FOR TRIP: As coordinator of Ottawa County's Lead Poisoning Prevention Program, I have been asked to present 2 breakout sessions on successful project implementation in 2 sessions, one on 2/12 and another 2/14. Funding for this travel is available through Ottawa County's Lead grant through ATSDR

DEPARTURE: 2/11/02 Early Morning need to there by 3:30 pm DATE OF RETURN: 2/14/02 4:00-6:00 pm

MODE OF TRANSPORTATION (Private – Public): Airline Ticket: X Car: _____ Bus: _____
(If traveling by car a cost comparison must be attached)

DURATION OF TRIP WILL INCLUDE: 4 DAYS AT MEETING AND 2 DAYS ENROUTE

TOTAL NUMBER OF DAYS: 4

ESTIMATED COST: $ ~~345.00~~ 417.50 (Travel) $ 152.00 (Per Diem) $ 400.00 (Other) motel $ ~~797.00~~ 969.50 (Total)

APPROVED

J Nichols / sw
(Division Director/Service Chief)

FINANCIAL MANAGEMENT

Ottawa Co Lead Grant

FUNDING: 400BT22 (Fund) 000235NW97 (Account) 35005 (Sub-Activity) 93.200 (CFDA #)

Reimbursed by _____
(Used when non-OSDH resources are covering the entire cost of the meeting)

[signature] 01/24/02
(Financial Management Approval)

APPROVAL AND TRAVEL AUTHORIZATION

The individual named is authorized to perform official travel as indicated:

Steve W. Ronck (Name) Deputy Com (Title) 1-17-02 (Date)
(Executive Director/Deputy Commissioner/Commissioner)

OSDH Form No. 81
(Rev 10/2000)

Y003067-DS

TRAVEL AGENTS INCORPORATED
9415 North May Avenue at Britton
Oklahoma City, OK 73120
405/752-5252 • 405/752-7020 FAX

SALES PERSON: 66 ITINERARY/INVOICE NO. 0059081 DATE: 29 JAN 02
CUSTOMER NBR: 0000012057 DIVGKO PAGE: 01

TO: STATE DEPT OF HEALTH
1000 N.E. 10TH
OKLAHOMA CITY, OK. 73117
DLVR TO DWIGHT BURLESON 3RD FLOOR TRAVEL DIVSION
ORDERED BY ANGIE 271 1789
PURCHASE ORDER NUMBER Y0030670S
FOR: WALDRON/SUSAN

DELTA TICKETLESS CONFIRMATION NBR VKQ7NB

11 FEB 02 - MONDAY

AIR	DELTA AIR LINES INC	FLT:1616	COACH	
	LV TULSA		705A	EQP: BOEING 737-800
				01HR 50MIN
	AR ATLANTA		955A	NON-STOP
	ARRIVE: SOUTH TERMINAL			REF: VKQ7NB
	WALDRON/SUSAN	SEAT-13C		

14 FEB 02 - THURSDAY

AIR	DELTA AIR LINES INC	FLT:245	COACH	
	LV ATLANTA		510P	EQP: BOEING 737-800
	DEPART: SOUTH TERMINAL			02HR 01MIN
	AR TULSA		611P	NON-STOP
				REF: VKQ7NB
	WALDRON/SUSAN	SEAT-19C		

AIR TICKET	DL7076598781	WALDRON SUSAN	
ELEC TKT		BILLED TO	417.50*
		PERSONAL IDENTIFIER(S) REDACTED	
		SUB TOTAL	417.50
		NET CC BILLING	417.50*
		TOTAL AMOUNT DUE	0.00

NOTE...TAI IS NOT RESPONSIBLE FOR CHANGE FEES

Dec 04

AG-68

PLEASE RECONFIRM RETURNING AND CONTINUING RESERVATIONS 72 HOURS IN ADVANCE AND ARRIVE AT AIRPORT 2 HOURS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control
and Prevention (CDC)
Mailstop E-25
Atlanta, Georgia 30333
(404) 498-1420

December 17, 2001

Ms. Susan Waldron
Health Educator
Ottawa County Health Department
1930 N. Elm
Miami, OK 74354

Dear Ms. Waldron:

On behalf of the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Environmental Protection Agency (EPA), U. S. Housing and Urban Development (HUD), the Agency for Toxic Substances and Disease Registry (ATSDR), I am pleased that you have agreed to speak at the grantee's National Lead Health Education Conference. Approximately 250 lead health educators and representatives of state and local childhood lead poisoning prevention programs (CLPPPs) are expected to attend. The purpose of the conference is to improve the effectiveness of health education activities in CLPPPs nationwide. The theme of the conference if **"The Mission Is Possible: Lead-Safe Kids."**

The following is information about the session(s) for which you will be presenting or moderating:

Tuesday 2/12/02: 1:30 - 3:00 pm: Program Development and Implementation
Thursday 2/14/02: 10:00 – 11:15 am
A-1/F-3: Successful Program Development and Implementation (two concurrents A-1/F-3)
Format: Panel
Session Description:

Development and implementation are two vital first steps that can propel a lead health education program to success. In this session, speakers will describe the processes they used to develop and implement their local lead health education programs, highlighting aspects that worked well and pitfalls to be avoided. Based on sound program development and implementation principles, components to be addressed include: strategic program planning; use of surveillance and other data; theory-based educational interventions; collaborating and coordinating; and program evaluation.

The conference will be held at the **Hilton Atlanta, 255 Courtland Street, Atlanta, Georgia,** and will begin on Tuesday, February 12, 2002 at 8:30 a.m. All sessions will conclude on Thursday, February 14, 2002 at 12:30 p.m. Unless previously discussed with you, we are requesting that all speakers who are grantees make their own hotel and travel arrangements. The Hilton Atlanta room rates are $93.00 plus tax single occupancy or $118 plus tax double occupancy per night. **Hotel reservations can be made by calling toll free 1-(800)-445-8667, deadline January 4, 2002.** Please identify yourself as a participant of the CDC Lead Health Education Conference to secure the group rate

All guest speakers who will be traveled by one of the host agencies (not through your existing lead grants), please follow the directions below regarding your travel arrangements:

Agency Guest Speaker	Contact	Special Note
CDC	Sato Travel at (404) 633-0520/flight reservations Hilton Hotel at 1-800-445-8667 CDC travel contact: Latash Scruggs-Hill (404) 498-1429, zzv9@cdc.gov	Identify yourself as a traveler for the Lead Poisoning Prevention Branch, Executive Park, Building 6 ****Contract carriers must be utilized, no exceptions allowed.**
EPA	Darlene Watford (202) 260-3989 Watford.Darlene@epa.gov Hilton Hotel at 1-800-445-8667	Ms. Watford will provide you with further travel guidance
HUD	Staci Gilliam (202)-755-1785 x 110 Staci_N._Gilliam@HUD.GOV Hilton Hotel at 1-800-445-8667	Ms. Gilliam will provide you with further travel guidance

In preparation for the conference, please complete the enclosed speaker/moderator registration form and fax it to Joy Gulliksen at (404) 498-1444 by January 4, 2002. If you have any questions, or need additional information, please call Ms. Gulliksen (404) 498-1432 or e-mail jpg4@cdc.gov.

Please note: Speakers will be responsible for providing copies and handouts (approximately 75 copies for breakout sessions and 250 for plenary sessions). These materials should be mailed to the hotel at the following address:

Hilton Atlanta
Attn: Joy Gulliksen
255 Courtland Street
Atlanta, GA 30303

The hotel has limited storage space. Shipments are to arrive no earlier than February 9, 2002. Should the hotel need to return boxes for participants after the conference, the participant will be responsible for shipping fee, plus the handling charge of 50 cents per pound. All boxes should be marked--Hold for CDC Lead Health Education Conference.

We value your contribution and appreciate you taking time from your busy schedule to participate in this important event. We look forward to a successful conference.

Sincerely,

Gary P. Noonan, MPA, Acting Chief
Lead Poisoning Prevention Branch

Enclosure

leave from Tulsa

PROCUREMENT DIVISION PROCUREMENT DIVISION

OKLAHOMA STATE DEPARTMENT OF HEALTH
INTERSTATE TRAVEL REQUEST/AUTHORIZATION

2002 JAN 22 P 2:25 JAN 25 P 3:09

DIVISION: Ottawa County Health Dept. / Community Health Services

APPLICANT: Susan Waldron POSITION (Title): Health Educator

NATURE OF TRIP: 2002 National Lead Health Education Conference

The Mission Is Possible: Lead Safe Kids (Name) 2/11/02-2/14/02 (Date) Atlanta, GA (Location)

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(If traveling by car a cost comparison must be attached)

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TOTAL NUMBER OF DAYS: 4

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APPROVED

J Nichols / sw
(Division Director/Service Chief)

FINANCIAL MANAGEMENT

Ottawa Co Lead Grant

FUNDING: 400BT22 (Fund) 000235NW97 (Account) 35005 (Sub-Activity) 93.200 (CFDA #)

Reimbursed by _____
(Used when non-OSDH resources are covering the entire cost of the meeting)

[signature] 01/24/02
(Financial Management Approval)

APPROVAL AND TRAVEL AUTHORIZATION

The individual named is authorized to perform official travel as indicated:

[signature] Name Deputy Com Title 1-17-02
(Executive Director/Deputy Commissioner/Commissioner) (Date)

OSDH Form No. 81
(Rev 10/2000)

Time And Effort Cost
Cost Accumulation Schedule

June 13, 2003
Prepared By _____

Prog Cost Period: 10/2001 TO 03/2002
Program Code: 391

==ProgCost==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200110	85.29	186.98	0.21	845.04
200111	36.34	173.01	0.00	594.83
200112	79.59	117.27	0.00	870.41
200201	72.04	99.81	0.00	806.32
200202	59.00	75.58	0.00	590.28
200203	61.32	52.79	0.00	690.10
Total	**393.58**	**705.44**	**0.21**	**4,396.98**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200110	12.25	26.85	0.03	121.32
200111	4.08	19.40	0.00	66.71
200112	9.16	13.50	0.00	100.21
200201	8.61	11.93	0.00	96.35
200202	7.05	9.03	0.00	70.52
200203	7.40	6.37	0.00	83.27
Total	**48.55**	**87.08**	**0.03**	**538.38**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
97.54	213.83	0.24	966.36
40.42	192.41	0.00	661.54
88.75	130.77	0.00	970.62
80.65	111.74	0.00	902.67
66.05	84.61	0.00	660.80
68.72	59.16	0.00	773.37
442.13	**792.52**	**0.24**	**4,935.36**

EQUIPMENT

9/29/2001 to 3/31/2002

Claims	-
PROGCOST - Equipment	0.24
Total Equipment	$ 0.24

Claims are the direct costs and PROGCOST are the allocated costs. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

Time And Effort Cost
Cost Accumulation Schedule

June 13, 2003
Prepared By _____

Prog Cost Period: 10/2001 TO 03/2002
Program Code: 391

==ProgCost==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
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==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
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Total	**48.55**	**87.08**	**0.03**	**538.38**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
97.54	213.83	0.24	966.36
40.42	192.41	0.00	661.54
88.75	130.77	0.00	970.62
80.65	111.74	0.00	902.67
66.05	84.61	0.00	660.80
68.72	59.16	0.00	773.37
442.13	**792.52**	**0.24**	**4,935.36**

OTHER

9/29/2001 to 3/31/2002

Claims	22,167.70
PROGCOST - Other	4,935.36
Worker's Comp	77.01
Total Other	$ 27,180.07

Claims are the direct costs and PROGCOST are the allocated costs. These costs are for things like office supplies and test kits for blood lead. PROGCOST is allocated based on time charged to this program as a percentage of the total.

PERSONAL IDENTIFIER(S) REDACTED

OSF FORM 15-A
(Revised 1990)

** AGENCY COPY ** SVC CHF: NN

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y022975	227168

FOR AGENCY USE
WARRANT # 7860194 DATE: 03/11/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	3214	000000000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2271168

FOR
$ 195.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	195.00
011		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/12/2002	466036	195.00

THIS SPACE FOR AGENCY USE

400CX22 000235NN0A 3214AAAAAX 195.00

J/E XREF:

2178

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

03/05/2002
Date

Agency, Bd or Div. Use

The RKBlack Connection

RK Black Inc. CopySolutions Marathon

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
466036	DUE UPON RECEIPT

SHIP VIA:

227168 # C.

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

ACCOUNT #	PURCHASE ORDER NO.	SHIPPED DATE	INVOICE DATE
2716868	T072445	2/12/02	2/12/02

ORD.	SHIP	B.O.	U/M	DESCRIPTION / PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
1	1		EA	* MAINTENANCE CONTRACT NO. 18330 BILLING PERIOD FROM 3/2/02 THROUGH 4/1/02 AFICIO COLOR 3006 RICOH EPG	195.00		195.00	195.(
				SERIAL NO. 0100100116 SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013 DOES NOT INCLUDE SUPPLIES. RCV CONTRACT COUNTING DEVELOPMENTS NOT COPIES. RCV 7,500 DEVELOPMENTS/1,875 COPIES PER MONTH. RCV				
				SUBTOTAL				195.(
				FREIGHT				.(
				SALES TAX				.(
								195.(

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

730674578

Y022976	00P235NNQA
PURCHASE DOCUMENT	ACCOUNT NO.
011	400CX22
COMPLETE PARTIAL	FUND NO.
35005	3214AX
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
B Chen 3-5-02	
INVOICE APPROVED	DATE

PREPARED BY: Kay Odom

OKLAHOMA STATE DEPARTMENT OF HEALTH
FINANCIAL MANAGEMENT
JOURNAL ENTRY DOCUMENT

TRANS DATE: 03/05/02 DOCUMENT #: 021778 TODAY'S DATE: 04/15/02

REFERENCE #: CLAIM #: 227168

Vendor No.	Fund	Account	SubAcct	Object Code	Commodity	Debit	Credit
730674578	400CX22	000235NN0A	35005	3214AAAAAX			195.00
730674578	400BT22	000235NW97	35005	3214AAAAAX		195.00	
						195.00	195.00

REQUESTED: JAIMIE WATT DATE: 04/15/02 REASON: TO CORRECT FUNDING

APPROVED: [signature] DATE: LOSF 22530

ENTERED: [signature] DATE: 4/16/02

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y022975	223921

FOR AGENCY USE: WARRANT # 7756851 DATE: 02/08/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	3214	931970000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2 2 3 9 2 1

FOR
$ 195.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	195.00
010		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
01/07/2002	461855	195.00

THIS SPACE FOR AGENCY USE

400CX22 000235NN0A 3214AAAAAX 195.00

J/E XREF: 2170

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

02/04/2002

Title Date

Agency, Bd or Div. Use

The RKBlack Connection

RK Black Inc. CopySolutions Marathon

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
ED 461855	DUE UPON RECEIPT

SHIP VIA:

SOLD TO:
OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO:
DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

ACCOUNT #	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
2716868	T072445	OK HOUSE ACCOUN		1/07/02	1/07/02

ORD.	SHIP	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
				* MAINTENANCE CONTRACT NO. 18330					
				BILLING PERIOD FROM 2/2/02 THROUGH 3/1/02					
1	1		EA	AFICIO COLOR 3006	RICOH EPG	195.00		195.00	195.00
				SERIAL NO. 0100100116					
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
				DOES NOT INCLUDE SUPPLIES. RCV					
				CONTRACT COUNTING DEVELOPMENTS NOT COPIES.		RCV			
				7,500 DEVELOPMENTS/1,875 COPIES PER MONTH.		RCV			
						SUBTOTAL			195.00
						FREIGHT			.00
						SALES TAX			.00
									195.00

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

PREPARED BY: Kay Odom

OKLAHOMA STATE DEPARTMENT OF HEALTH
FINANCIAL MANAGEMENT
JOURNAL ENTRY DOCUMENT

TRANS DATE: 02/04/02 DOCUMENT #: 021779 TODAY'S DATE: 04/15/02

REFERENCE #: CLAIM #: 223921

Vendor No.	Fund	Account	SubAcct	Object Code	Commodity	Debit	Credit
730674578	400CX22	000235NN0A	35005	3214AAAAAX			195.00
730674578	400BT22	000235NW97	35005	3214AAAAAX		195.00	
						195.00	195.00

REQUESTED: JAIMIE WATT DATE: 04/15/02 REASON: TO CORRECT FUNDING

APPROVED: [signature] DATE: LOSF 22531

ENTERED: [signature] DATE: 4/16/02

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y022975	220913

FOR AGENCY USE
WARRANT # 7659160 DATE: 01/11/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	3214	931970000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2 2 0 9 1 3

FOR
$ 195.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRANT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
009		195.00

OSF AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
10/05/2001	450611	195.00

THIS SPACE FOR AGENCY USE

400CX22 000235NN0A 3214AAAAAX 195.00

J/E XREF:
2180

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

01/08/2002

Title Date

Agency, Bd or Div. Use

01/07/02 MON 08:42 FAX 405 943 7023 RK BLACK 001

220913 P.C.

The RKBlack Connection

RKBlack Inc. COPYSOLUTIONS MergeOne

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9884

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

SHIP VIA:

SOLD

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP

DEQ OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

1	1		EA	* MAINTENANCE CONTRACT NO. 18330 BILLING PERIOD FROM 11/2/01 THROUGH 12/1/01 AFICIO COLOR 3006 RICOH EPG SERIAL NO. 0100100116 SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013 DOES NOT INCLUDE SUPPLIES. RCV CMI 04/05/01 AR	195.00		195.00	195.00
						SUBTOTAL		195.00
						FREIGHT		.00
						SALES TAX		.00

I Certify this ~~to be~~ as a Faxed copy of the invoice Submitted by The Vendor

Y 022975

• 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
• RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
• RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

Please show INVOICE and ACCOUNT # on remittance

01/07/02 MON 08:43 FAX 405 943 7023 RK BLACK 003

45 0611
458-45

R.K. Black, Inc.

4111 Perimeter Center
Oklahoma City, Ok 73112
(405) 943-9804 EX 146

TO: Ronnie FAX:# 271-3037

Phone# 271-9444 EX 56324

FROM: Ruby Wilkey DATE: 1/7/2002

COMMENTS: (Invoice 450611 is open.)
Thanks!

We are sending 3 Pages(including cover sheet).

PREPARED BY: Kay Odom

OKLAHOMA STATE DEPARTMENT OF HEALTH
FINANCIAL MANAGEMENT
JOURNAL ENTRY DOCUMENT

TRANS DATE: 01/08/02 DOCUMENT #: 021780 TODAY'S DATE: 04/15/02

REFERENCE #: CLAIM #: 220913

Vendor No.	Fund	Account	SubAcct	Object Code	Commodity	Debit	Credit
730674578	400CX22	000235NN0A	35005	3214AAAAAX			195.00
730674578	400BT22	000235NW97	35005	3214AAAAAX		195.00	
						195.00	195.00

REQUESTED: JAIMIE WATT DATE: 04/15/02 REASON: TO CORRECT FUNDING

APPROVED: [signature] DATE: LOSF 22532

ENTERED: mo DATE: 4/16/02

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y022975	220293

FOR AGENCY USE
WARRANT # 7635429 DATE: 01/07/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	3214	000000000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2
2
0
2
9
3

FOR
$ 195.00

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
008		195.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/10/2001	458545	195.00

THIS SPACE FOR AGENCY USE

400CX22 000235NN0A 3214AAAAAX 195.00

J/E XREF: 21781

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

01/03/2002
Date

Agency, Bd or Div. Use

The KBlack Connection

Black Inc. CopySolutions Marathon

METER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
458545	DUE UPON RECEIPT

SHIP VIA:

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ--OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO	SHIPPING DATE	INVOICE DATE
6868	T072445	OK HOUSE ACCOUN		12/10/01	12/10/01

QTY	B.O.	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
			* MAINTENANCE CONTRACT NO. 18330					
			BILLING PERIOD FROM 1/2/02 THROUGH 2/1/02					
1		EA	ARICIO COLOR 3006	RICOH EPG	195.00		195.00	195.0
			SERIAL NO. 0100100116					
			SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
			DOES NOT INCLUDE SUPPLIES. RCV					
			CONTRACT COUNTING DEVELOPMENTS NOT COPIES. RCV					
			7,500 DEVELOPMENTS/1,875 COPIES PER MONTH. RCV					
						SUBTOTAL		195.0
						FREIGHT		.0
						SALES TAX		.0
						Please show INVOICE and ACCOUNT # on remittance		195.0

MONTH (18% PER ANNUM) SERVICE CHARGE ON ALL PAST DUE BALANCES
NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
SUBJECT TO A 15% RESTOCKING CHARGE

(01)

730674578

Y022975	000235NNOA
PURCHASE DOCUMENT	ACCOUNT NO.
COMPLETE / 008 PARTIAL	400CX22
	FUND NO. 14-X
35006	3214 X
MATH CHECKED	OBJECT CODE
CLAIM ENTERED	CLAIM NUMBER
B. Chen 12-18-01	
INVOICE APPROVED	DATE

PREPARED BY: Kay Odom

OKLAHOMA STATE DEPARTMENT OF HEALTH
FINANCIAL MANAGEMENT
JOURNAL ENTRY DOCUMENT

TRANS DATE: 01/03/02 DOCUMENT #: 021781 TODAY'S DATE: 04/15/02

REFERENCE #: CLAIM #: 220293

Vendor No.	Fund	Account	SubAcct	Object Code	Commodity	Debit	Credit
730674578	400CX22	000235NN0A	35005	3214AAAAAX			195.00
730674578	400BT22	000235NW97	35005	3214AAAAAX		195.00	
						195.00	195.00

REQUESTED: JAIMIE WATT DATE: 04/15/02 REASON: TO CORRECT FUNDING

APPROVED: MD DATE: LOSF 22533

ENTERED: ad DATE: 4/16/02

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NN

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y022975	216860

FOR AGENCY USE
WARRANT # 7535101 DATE: 12/04/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	3214	931970000	195.00

CLAIM OF:
R K BLACK/COPY SOLUTIONS
730674578

2
1
6
8
6
0

FOR
$ 195.00

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

_____

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date: _____

Claimant: _____

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
007		195.00

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/08/2001	455049	195.00

THIS SPACE FOR AGENCY USE

400CX22 000235NN0A 3214AAAAAX 195.00

J/E XREF:
21782

VENDOR: R K BLACK/COPY SOLUTIONS
ADDRESS: 4111 PERIMETER CENTER PLACE
ADDRESS:
CITY/ST/ZIP: OKLAHOMA CITY OK 731129984

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I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

11/30/2001

Title Date

Agency, Bd or Div. Use

The RKBlack Connection

RK Black Inc. COPYSOLUTIONS Marathon

4111 PERIMETER CENTER PLACE OKLAHOMA CITY, OKLA. 73112-9984

(405) 943-9801

216860

INVOICE

★ Please pay on invoice, no statement will be sent, unless invoice becomes past due.

INVOICE #	TERMS
455049	DUE UPON RECEIPT

SHIP VIA:

SOLD TO

OKLAHOMA STATE DEPT OF
HEALTH PROCUREMENT DIV
1000 N.E. 10TH STREET
OKLAHOMA CITY OK 73117-1299

SHIP TO

DEQ-OTTAWA COUNTY
1930 NORTH ELM
MIAMI OK 74354

ACCOUNT #	PURCHASE ORDER NO.	SALES PERSON	SHIPPING NO.	SHIPPING DATE	INVOICE DATE
2716868	T072445	OK HOUSE ACCOUN		11/08/01	11/08/01

ORD.	SHIP	B.O.*	U/M	DESCRIPTION	PRODUCT NUMBER	UNIT PRICE	DISC.	NET PRICE	AMOUNT
				* MAINTENANCE CONTRACT NO. 18330					
				BILLING PERIOD FROM 12/2/01 THROUGH 1/1/02					
1	1		EA	AFICIO COLOR 3006	RICOH EPG	195.00		195.00	195.00
				SERIAL NO. 0100100116					
				SERVICE BY IKON IN JEFFERSON CITY. 573-556-2013					
				DOES NOT INCLUDE SUPPLIES. RCV					
				CONTRACT COUNTING DEVELOPMENTS NOT COPIES. RCV					
				7,500 DEVELOPMENTS/1,875 COPIES PER MONTH. RCV					
						SUBTOTAL			195.00
						FREIGHT			.00
						SALES TAX			.00
						Please show INVOICE and ACCOUNT # on remittance			195.00

Y022975
Y022975
X077835

PURCHASE DOCUMENT: [illegible] ACCOUNT NO.: 00023[illegible]
COMPLETE: [illegible] PARTIAL: 007 FUND NO.: 400CX22
SUB ACTIVITY: 3700[illegible] OBJECT CODE: 3214 [illegible]
MATH: ENTERED: CLAIM NUMBER:
B. Chen 11-21-01
INVOICE APPROVED DATE

73674578

(11)

- 1½% PER MONTH (18% PER ANNUM) SERVICE CHARGE ON PAST DUE INVOICES
- RETURNS NOT ACCEPTED WITHOUT PRIOR WRITTEN AUTHORIZATION
- RETURNS SUBJECT TO A 15% RESTOCKING CHARGE

PREPARED BY: Kay Odom

OKLAHOMA STATE DEPARTMENT OF HEALTH
FINANCIAL MANAGEMENT
JOURNAL ENTRY DOCUMENT

TRANS DATE: 11/30/01 DOCUMENT #: 021782 TODAY'S DATE: 04/15/02

REFERENCE #: CLAIM #: 216860

Vendor No.	Fund	Account	SubAcct	Object Code	Commodity	Debit	Credit
730674578	400CX22	000235NN0A	35005	3214AAAAAX			195.00
730674578	400BT22	000235NW97	35005	3214AAAAAX		195.00	
						195.00	195.00

REQUESTED: JAIMIE WATT DATE: 04/15/02 REASON: TO CORRECT FUNDING

APPROVED: [signature] DATE: LOSF 22534

ENTERED: [signature] DATE: 4/16/02

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y032174	218367

FOR AGENCY USE
WARRANT # 7591156 DATE: 12/18/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	5511	939400000	3,566.33

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 3,566.33

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
001		3,566.33

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY):

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
11/01/2001	OCT 2001	3,566.33

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 5511AAAAAX 3566.33

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS: 715 WEST A STREET
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

12/13/2001

Title Date

Agency, Bd or Div. Use

218367

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

INVOICE

Bill To:	Remit To:
OKLA. STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N.E. 10TH STREET OKLAHOMA CITY, OKLAHOMA 73117-1299	PICHER-CARDIN PUBLIC SCHOOL P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 11-1-2001
Billing Period: 10-1-2001 → 10-31-2001
Purchase Order #: Y032174

Contractor Representative:
Bob Walker, Superintendent
918-673-1714

Item	Quantity	Unit	Description	Unit Price (salary + fringes)	Amount
001	152.25	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	13.46	2,049.29
001	168	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	9.03	1,517.04
				Total Amount	$3,566.33

12/11/01

Y032174 PURCHASE DOCUMENT
001
35005
12/11/01
218367
INVOICE APPROVED DATE

Total number of students served during this billing period: 450

Copies of Time and Effort sheets that reflect each duty as an activity code: attached

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Cheryl Ross

Date	Lead Poisoning Prevention Curriculum Hours	Reading, Math, Speech Assistance Hours	Total hours
10/1 101		7.25	7.25
10/2		7.25	7.25
10/3	2	5.25	7.25
10/4		7.25	7.25
10/5	5	2.25	7.25
10/8		7.25	7.25
10/9		7.25	7.25
10/10	2	5.25	7.25
10/11		7.25	7.25
10/12	5	2.25	7.25
10/15		7.25	7.25
10/16		7.25	7.25
10/17	2	5.25	7.25
10/22		7.25	7.25
10/23		7.25	7.25
10/24	5	2.25	7.25
10/25		7.25	7.25
10/26	5	2.25	7.25
10/29		7.25	7.25
10/30	2	5.25	7.25
10/31	5	2.25	7.25
		Total Time Sheet Hours	152.25

Employee signature: Cheryl Ross **Date:** 10/31/01

Supervisor signature: [signature] **Date:** 10/31/01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: JoAnn Roberts

Date	Lead Poisoning Prevention Curriculum Hours	Reading, Math, Speech Assistance Hours	Total hours
10/1/01		8	8
10/2		8	8
10/3		8	8
10/4	4	4	8
10/5	4	4	8
10/8		8	8
10/9		8	8
10/10		8	8
10/11	4	4	8
10/12	4	4	8
10/15		8	8
10/16		8	8
10/17	4	4	8
10/22		8	8
10/23		8	8
10/24		8	8
10/25	4	4	8
10/26	4	4	8
10/29		8	8
10/30		8	8
10/31	4	4	8
		Total Time Sheet Hours	168

Employee signature: JoAnn Roberts **Date:** 10/31/01

Supervisor signature: BM Walker **Date:** 10/31/01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y032174	218688

FOR AGENCY USE
WARRANT # 7603730 DATE: 12/20/2001

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	5511	000000000	3,223.31

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 3,223.31

AGAINST

Agency, Board, Comm., Dept.: Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to _____

and authorize the State Treasurer to issue a warrant in payment to said assignee.

Date: _____

Claimant: _____

WARREN (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	3,223.31
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/01/2001	NOV 2001	3,223.31

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 5511AAAAAX 3223.31

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS:
CITY/ST/ZIP: PICHER OK 74360

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

12/17/2001

Title Date

Agency, Bd or Div. Use

12/13/01

218688 LL

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

INVOICE

Bill To:	Remit To:
OKLA. STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N.E. 10TH STREET OKLAHOMA CITY, OKLAHOMA 73117-1299	PICHER-CARDIN PUBLIC SCHOOL P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 12/1/01
Billing Period: 11/1 - 11/30/01
Purchase Order #: Y032174

Contractor Representative:
Bob Walker, Superintendent
918-673-1714

Item	Quantity	Unit	Description	Unit Price (salary + fringes)	Amount
001	137.5	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	13.46	~~1,854.12~~ 1850.75
001	152	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	9.03	1,372.56
				Total Amount	~~$3,226.68~~ 3223.31

736021187A 12/13/01

Y032174 PURCHASE DOCUMENT
002 COMPLETE
35005 MATH
000235NW97 ACCOUNT NO.
400BF22
5511AX
218688
CLAIM ENTERED 12/17/01
INVOICE APPROVED DATE

11

Total number of students served during this billing period: 450

Copies of Time and Effort sheets that reflect each duty as an activity code: attached

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Cheryl Ross

Date	Lead Poisoning Prevention Curriculum Hours	Reading, Math, Speech Assistance Hours	Total hours
11/1/01	2	5.25	7.25
11/2	5	2.25	7.25
11/5		7.25	7.25
11/6		7.25	7.25
11/7	2	5.25	7.25
11/8		7.25	7.25
11/9	5	2.25	7.25
11/12		7.25	7.25
11/13		7.25	7.25
11/14	2	5.25	7.25
11/15		7.25	7.25
11/16	5	2.25	7.25
11/19		7.25	7.25
11/20		7.25	7.25
11/26		7.25	7.25
11/27		7.25	7.25
11/28	2	5.25	7.25
11/29		7.25	7.25
11/30	5	2.25	7.25

Total Time Sheet Hours	137.75

Employee signature: Cheryl Ross **Date:** 11-30-01

Supervisor signature: Bob Walker **Date:** 11/30/01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Jo Ann Roberts

Date	Lead Poisoning Prevention Curriculum Hours	Reading, Math, Speech Assistance Hours	Total hours
11/1/01	4	4	8
11/2	4	4	8
11/5		8	8
11/6		8	8
11/7		8	8
11/8	4	4	8
11/9	4	4	8
11/12		8	8
11/13		8	8
11/14		8	8
11/15	4	4	8
11/16	4	4	8
11/19		8	8
11/20		8	8
11/26		8	8
11/27		8	8
11/28		8	8
11/29	4	4	8
11/30	4	4	8

Total Time Sheet Hours	152

Employee signature: Joann Roberts **Date:** 11/30/01

Supervisor signature: [signature] **Date:** 11/30/01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y041261	220167

FOR AGENCY USE
WARRANT # 7635380 DATE: 01/07/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	5511	841810000	4,082.53

CLAIM OF:
OTTAWA COUNTY HLTH DEPT (58)
736006404

FOR
$ 4,082.53

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to
_____
and authorize the State Treasurer to issue a warrent in payment to said assignee.
Date: _____
Claimant: _____

WARRENT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	4,082.53
001		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20011130

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
12/17/2001	5802LG1116	4,082.53

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 5511AAAAAX 4082.53

J/E XREF:

VENDOR: OTTAWA COUNTY HLTH DEPT (58)
ADDRESS: 1930 N. ELM
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74354

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

01/02/2002
Date

Agency, Bd or Div. Use

INVOICE NUMBER 58021G11-16 ;;;;;;;;; 12-17-01, 19
Date Prepared

NAME Ottawa County Health Dept. FID/SSN 73-6006404

Mailing Address (Street/Box Number) 1930 North Elm

City Miami State OK Zip 74354 -

Service Date MO	DAY	YEAR	Description of Service Rendered	Units Of Svc	Price ($) Per Unit	TOTAL (Unit X $)
10	31	02	Reimburse OCHD LEP Expenses for 10-01			$3984.04
11	30	01	Reimburse OCHD LEP Expenses for 11-01			98.49
			PO#Y041261			
					TOTAL	$4082.53

STATE OF OKLAHOMA, COUNTY OF Ottawa

The undersigned (architect, contractor, supplier or engineer), of lawful age, being first duly sworn, on oath says that this (invoice, claim or contract) is true and correct. Affiant further states that the (work, services, or materials) as shown by this invoice or claim have been (completed or supplied) in accordance with the plans, specifications, orders or requests furnished the affiant. Affiant further states that (s)he has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly, to any elected official, officer or employee of the State of Oklahoma, of money or any other thing of value to obtain payment or the award of this contract.

Architect, Contractor, Supplier or Engineer

Subscribed and sworn to before me this 17th day of December 2001, 19

My commission expires: 07-14-04

Notary Public (County Clerk or Judge)

OFFICIAL USE ONLY:

PO # or CT #	Account Number
Complete-Partial	Fund Number
Sub-Activity	Object Code
Math Entered	Claim Number
INV Funded By	Date

APPROVED FOR PAYMENT

12/18/01

Program Supervisor

Oklahoma State Department of Health
Financial Management Service - 0102
1000 N.E. 10th St.
Oklahoma City, Oklahoma 73117-1299

OKLAHOMA STATE DEPARTMENT OF HEALTH
Financial Management Service

INVOICE

12/91 ODH FORM 8

PRG:REPT/EXPENSE
VER:3.50 PROGRAM EXPENDITURE REPORT FOR CA 16:23:36
FROM 10/12/01 TO 11/08/01 11/19/01

58 OTTAWA CO CA 11/1901 PAGE 1

BASIC HEALTH

ACCT#	DATE PAID	DEP#	PO#	WRNT#	PAYEE	AMOUNT PAID	CODES EX	DP
93D	11/08/01		1765	112	U.S. CELLULAR	84.28	25	
					SUB-TOT FOR EXPENSE #25	84.28		
93D	11/08/01		854	103	RC AD SPECIALTIES	2156.76	27	
93D	11/08/01		1278	95	PHYSICIANS SALES & SERVIC	224.00	27	
93D	11/08/01		1591	100	PAPAZANO'S	109.00	27	
93D	11/08/01		1642	107	RC SALES AD SPECIALTIES	1410.00	27	
					SUB-TOT FOR EXPENSE #27	3899.76		

ENDING BALANCE -3984.04

MONTHLY DEPOSITS 0.00
MONTHLY EXPENSES 3984.04

Lerd

PRG:REPT/EXPENSE
VER:3.50 PROGRAM EXPENDITURE REPORT FOR CA 10:40:20
FROM 11/15/01 TO 12/12/01 12/13/01

58 OTTAWA CO CA 12/1901 PAGE 1

BASIC HEALTH

ACCT#	DATE PAID	DEP#	PO#	WRNT#	PAYEE	AMOUNT PAID	CODES EX	CODES DP
93D	11/29/01		2147	145	U.S. CELLULAR	61.18	25	
					SUB-TOT FOR EXPENSE #25	61.18		
93D	11/29/01		1564	131	WAL-MART	37.31	27	
					SUB-TOT FOR EXPENSE #27	37.31		
					ENDING BALANCE	-98.49		
					MONTHLY DEPOSITS	0.00		
					MONTHLY EXPENSES	98.49		

** AGENCY COPY ** SVC CHF: NW

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y032174	221851

FOR AGENCY USE
WARRANT # 7686974 DATE: 01/18/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	5511	000000000	2,547.38

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 2,547.38

AGAINST
Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to _____
and authorize the State Treasurer to issue a warrant in payment to said assignee.
Date: _____
Claimant: _____

WARRANT (LOCATOR NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
003		2,547.38

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY) _____

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
01/01/2002	JAN-02	2,547.38

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 5511AAAAAX 2547.38

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS:
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

01/15/2002
Date

Agency, Bd or Div. Use

22184/P.C.

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

RECEIVED
JAN 04 2002
OTTAWA COUNTY HEALTH DEPT.

INVOICE

Bill To:	Remit To:
OKLA. STATE DEPT. OF HEALTH **Procurement-Contracts Unit** 1000 N.E. 10TH STREET OKLAHOMA CITY, OKLAHOMA 73117-1299	PICHER-CARDIN PUBLIC SCHOOL P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 1/1/02
Billing Period: 12/1/01 - 12/31/01
Purchase Order #: Y032174

Contractor Representative:
Bob Walker, Superintendent
918-673-1714

Item	Quantity	Unit	Description	Unit Price (salary + fringes)	Amount
001	108.75	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	13.46	1,463.78
001	120	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	9.03	1,083.60
			736021187	1/11/01	
				Total Amount	$2,547.38

Y032174 PURCHASE DOCUMENT
000235NW99 ACCOUNT NO.
003 COMPLETE PARTIAL
400 8722 FUND NO.
36005 MATH CHECKED
E511AX OBJECT CODE
CLAIM ENTERED
CLAIM NUMBER
B. Chen 1-15-02
INVOICE APPROVED DATE

Total number of students served during this billing period: 450

Copies of Time and Effort sheets that reflect each duty as an activity code: attached

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: Cheryl Ross

Date	Lead Poisoning Prevention Curriculum Hours	Reading, Math, Speech Assistance Hours	Total hours
12/3/01		7.25	7.25
12/4		7.25	7.25
12/5	2	5.25	7.25
12/6		7.25	7.25
12/7	5	2.25	7.25
12/10		7.25	7.25
12/11		7.25	7.25
12/12	2	5.25	7.25
12/13		7.25	7.25
12/14	5	2.25	7.25
12/17		7.25	7.25
12/18		7.25	7.25
12/19	2	5.25	7.25
12/20		7.25	7.25
12/21	5	2.25	7.25

Total Time Sheet Hours	108.75

Employee signature: Cheryl Ross **Date:** 12-21-01

Supervisor signature: Bob Walker **Date:** 12/21/01

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

TIME SHEET

Employee name: JoAnn Roberts

Date	Lead Poisoning Prevention Curriculum Hours	Reading, Math, Speech Assistance Hours	Total hours
12/3/01		8	8
12/4		8	8
12/5		8	8
12/6	4	4	8
12/7	4	4	8
12/10		8	8
12/11		8	8
12/12		8	8
12/13	4	4	8
12/14	4	4	8
12/17		8	8
12/18		8	8
12/19		8	8
12/20	4	4	8
12/21	4	4	8
		Total Time Sheet Hours	120

Employee signature: Joann Roberts **Date:** 12-21-01

Supervisor signature: Bob Walker **Date:** 12/21/01

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y041261	228344

FOR AGENCY USE
WARRANT # 7887176 DATE: 03/18/2002

CLAIM OF:
OTTAWA COUNTY HLTH DEPT (58)
736006404

2
2
8
3
4
4

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	5511	932179999	1,149.97

FOR
$ 1,149.97

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant:

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $	1,149.97
002		OSF-AUDITED BY	

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20020131

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/19/2002	5802LG0225	1,149.97

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 5511AAAAAX 1149.97

J/E XREF:

VENDOR: OTTAWA COUNTY HLTH DEPT (58)
ADDRESS: 1930 N. ELM
ADDRESS:
CITY/ST/ZIP: MIAMI OK 74354

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/14/2002

Title Date

Agency, Bd or Div. Use

INVOICE NUMBER 5802IG02-25

02-19-02, 19
Date Prepared

NAME Ottawa County Health Dept. FID/SSN 736006404

Mailing Address (Street/Box Number) 1930 N. Elm

City Miami State OK Zip 74354 -

Service Date MO	DAY	YEAR	Description of Service Rendered	Units Of Svc	Price ($) Per Unit	TOTAL (Unit X $)
01	31	02	Reimburse Ottawa CHD expenses for			
			Lead Prevention Grant per attached LEB			$1149.97
				TOTAL		$1149.97

STATE OF OKLAHOMA, COUNTY OF Ottawa

The undersigned (architect, contractor, supplier or engineer), of lawful age, being first duly sworn, on oath says that this (invoice, claim or contract) is true and correct. Affiant further states that the (work, services, or materials) as shown by this invoice or claim have been (completed or supplied) in accordance with the plans, specifications, orders or requests furnished the affiant. Affiant further states that (s)he has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly, to any elected official, officer or employee of the State of Oklahoma, of money or any other thing of value to obtain payment or the award of this contract

Jana Ann Nicholson
Architect, Contractor, Supplier or Engineer

Subscribed and sworn to before me this 19th day of February 19 2002

My commission expires: 08-14-04

Notary Public (County Clerk or Judge)

OFFICIAL USE ONLY

54126	
PO # or CT #	Account Number
/ /	
Complete-Partial	Fund Number
	211
Sub-Activity	Object Code
/ /	
Math Entered	Claim Number
02	3-1-02
INV Funded By	Date

APPROVED FOR PAYMENT

Program Supervisor

Oklahoma State Department of Health
Financial Management Service - 0102
1000 N.E. 10th St.
Oklahoma City, Oklahoma 73117-1299

OKLAHOMA STATE DEPARTMENT OF HEALTH
Financial Management Service

INVOICE

12/91 ODH FORM 8

FUNDING SHEET

PURCHASE ORDER	Y041261			
MEDICAL DIRECTORS	192KFX2	010240W097 40002	1570AAAAAY	
CHILD HEALTH CLINICS	400AR22	000235NC97 42000	1514AAAAAX	
FAMILY PLANNING CLINICS	400CM22	000235TS97 35001	1514AAAAAX	
MATERNITY CLINICS	400AR22	000235TQ97 35001	1514AAAAAX	
DOT	400BA22	000220PE97 20002	5125AAAAAY	
TB	192KCX2	010220PE97 20002	5514AAAAAX	
WIC	400EA12	000235VG97 69000	1594AAAAAX	
BRST&CERV CANCER	192KCX2	170220RV97 20003	1570AAAAAY	
HIV-STD	400CP22	000220PA97 20004	5514AAAAAX	
CHD EXPENSES	192KFX2	010240W097 40002	1579AAAAAX	
DENTAL SERVICES	192KDX2	150235QC97 35007	1599AAAAAX	~~$12,012.07~~
MCH-CONGENIALDISORDER	400AR22	000235T40A 35005	1578AAAAAX	
CHILD HEALTH & GUIDANCE	265KDX2	000235NE97 41000	1594AAAAAX	
ADOLESCENT	192KFX2	010240NK40 40002	5511AAAAAX	
ABSTINENCE	400AT12	000235TN97 44000	1594AAAAAX	
COMMUNITY HEALTH	192KFX2	030240WT74 40002	1579AAAAAX	
ADMINISTRATION	192KDX2	010235QA0A 00001	2215AAAAAX	
WEST NILE VIRUS	400CQ12	000220PB0A 20002	3721AAAAAX	
CH&G- CHILD ABUSE TRAIN	210YV12	000235NE0A 41000	3213AAAAAX	
COMMISSIONER'S OFFICE	192KAX2	010201AA0A 00001	1599AAAAAX	
CHILD DEFECTS	400CN12	0002352G0A 35005	1911AAAAAX	
PHS-EPI&LAB CAP/ID	400CQ22	000220PR0A 20002	3911AAAAAX	
IMMUNIZATION	400CD22	000220PG97 20005	1599AAAAAX	

EARLY INTERVENTION	400GY22	000235VM11 60000	1576AAAAAY	
ELDERCARE	260KPX2	000240VL97 51000	5514AAAAAX	
OTTAWA LEAD PROJECT	400BT22	000235NW97 35005	5511AAAAAX	$1,149.97

PREPARED BY PATRICK ISAAC

Pat 3-13-02

PRG:REPT/EXPENSE
VER:3.50 PROGRAM EXPENDITURE REPORT FOR CA 14:22:28
FROM 12/18/01 TO 01/18/02 01/18/02

58 OTTAWA CO CA 1/2002 PAGE 1

BASIC HEALTH

ACCT#	DATE PAID	DEP#	PO#	WRNT#	PAYEE	AMOUNT PAID	CODES EX	DP
93D	01/11/02		2623	174	U.S. CELLULAR	61.18	25	
					SUB-TOT FOR EXPENSE #25	61.18		
93D	01/11/02		2617	171	OUHFC:DR. MARK COX	390.00	26	
					SUB-TOT FOR EXPENSE #26	390.00		
					ENDING BALANCE	-451.18		
					MONTHLY DEPOSITS	0.00		
					MONTHLY EXPENSES	451.18		

1 of 1

PRG:REPT/EXPENSE
VER:3.50 PROGRAM EXPENDITURE REPORT FOR CA 12:43:48
FROM 01/16/02 TO 02/06/02 02/19/02

58 OTTAWA CO CA 2/1902 PAGE 1

BASIC HEALTH

ACCT#	DATE PAID	DEP#	PO#	WRNT#	PAYEE	AMOUNT PAID	CODES EX DP
93D	01/23/02		2923	189	U.S. CELLULAR	61.18	25
					SUB-TOT FOR EXPENSE #25	61.18	
93D	01/16/02		2442	181	OFFICE DEPOT	58.67	27
93D	01/16/02		2625	182	MICRO WAREHOUSE	489.95	27
93D	02/06/02		2880	198	OFFICE DEPOT	9.49	27
93D	02/06/02		2935	199	KENNETH WAGENER	79.50	27
					SUB-TOT FOR EXPENSE #27	637.61	
					ENDING BALANCE	-698.79	
					MONTHLY DEPOSITS	0.00	
					MONTHLY EXPENSES	698.79	

Lopo, Tom G.

From: Lopo, Tom G.
Sent: Monday, March 04, 2002 7:41 AM
To: Admin Review Team
Subject: FW: OTTAWA CO. HEALTH DEPT PO Y041261

-1360064

-----Original Message-----
From: Isaac, Patrick L.
Sent: Friday, March 01, 2002 4:32 PM
To: Lopo, Tom G.
Subject: OTTAWA CO. HEALTH DEPT PO Y041261

I have an invoice from Ottawa Co. Health Dept for $1149.97 for the reimbursement of Ottawa CHD expenses for Lead Prevention Grant . The Purchase order number is Y041261 400BT22 000235NW97 35005 . The problem is that in Adpics the Vendor Name is Ottawa Co. Commissioners and the Name on the invoice is for Ottawa Co. Health Dept. Which name is the Correct Vendor to pay this invoice to?

Isaac, Patrick L.

From: Isaac, Patrick L.
Sent: Friday, March 01, 2002 4:32 PM
To: Lopo, Tom G.
Subject: OTTAWA CO. HEALTH DEPT PO Y041261

I have an invoice from Ottawa Co. Health Dept for $1149.97 for the reimbursement of Ottawa CHD expenses for Lead Prevention Grant . The Purchase order number is Y041261 400BT22 000235NW97 35005 . The problem is that in Adpics the Vendor Name is Ottawa Co. Commissioners and the Name on the invoice is for Ottawa Co. Health Dept. Which name is the Correct Vendor to pay this invoice to?

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y032174	229005

FOR AGENCY USE
WARRANT # 7910207 DATE: 03/25/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	5511	000000000	3,566.33

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

2229005

FOR
$ 3,566.33

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT
I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant

WARRENT (LOCATOR) NO.

Enter the partial payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
004		3,566.33

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20020131

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
02/01/2002	FEB02	3,566.33

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 5511AAAAAX 3566.33

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS:
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

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Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

03/20/2002

Title Date

Agency, Bd or Div. Use

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

INVOICE

RECEIVED
2002 MAR 15 P 4: 49
FINANCIAL MANAGEMENT

Bill To:	Remit To:
OKLA. STATE DEPT. OF HEALTH Procurement-Contracts Unit 1000 N.E. 10TH STREET OKLAHOMA CITY, OKLAHOMA 73117-1299	PICHER-CARDIN PUBLIC SCHOOL P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

229005

Invoice Date: 2/1/02
Billing Period: 1/3/02 - 1/31/02
Purchase Order #: Y032174

Contractor Representative:
Bob Walker, Superintendent
918-673-1714

Item	Quantity	Unit	Description	Unit Price (salary + fringes)	Amount
001	152.25	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	13.46	2.049.29
001	168	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	9.03	1,517.04
				Total Amount	$3,566.33

Y032174 PURCHASE DOCUMENT
000235 0097 ACCOUNT NO
COMPLETE
009 PARTIAL
400 BT22 FUND NO.
35005 SUB ACTIVITY
55 11 A-X OBJECT CODE
MATH
ENTERED
SUBMIT NUMBER
INVOICE APPROVED
3/20/02 DATE

OK K- 3/15/02

Total number of students served during this billing period: 450

Copies of Time and Effort sheets that reflect each duty as an activity code: attached

OSF FORM 15A
(Revised 1990)

STATE OF OKLAHOMA
Claim Jacket Form

** AGENCY COPY ** SVC CHF: NW

FUND	AGENCY	ORDER NO.	CLAIM NO.
400	340	Y032174	229007

FOR AGENCY USE
WARRANT # 7910209 DATE: 03/25/2002

ACCOUNT	SUB-ACTIVITY	OBJECT	CFDA	AMOUNT
000235	35005	5511	939400000	3,056.85

CLAIM OF:
PICHER-CARDIN PUBLIC SCHOOL
736021187

FOR
$ 3,056.85

AGAINST

Agency, Board, Comm., Dept.
Okla. State Dept. of Health

ASSIGNMENT

I hereby assign this claim to

and authorize the State Treasurer to issue a warrent in payment to said assignee.

Date:

Claimant

WARRENT (LOCATOR) NO.

Enter the partial payment or final payment number if claim is to be charged against an encumbered order.

Partial No.	Final No.	TOTAL AMOUNT $
005		3,056.85

OSF-AUDITED BY

Receipt of Goods or Services Date
(OFFICE OF PUBLIC AFFAIRS ISSUED CONTRACTS ONLY): 20020228

SUMMERIZED INFORMATION RELATIVE TO THE ATTACHED INVOICES OR CONTRACT ESTIMATES

INVOICE DATE	INVOICE NO.	AMOUNT
03/01/2002	MAR02	3,056.85

THIS SPACE FOR AGENCY USE

400BT22 000235NW97 5511AAAAAX 3056.85

J/E XREF:

VENDOR: PICHER-CARDIN PUBLIC SCHOOL
ADDRESS: PO BOX 280
ADDRESS:
CITY/ST/ZIP: PICHER OK 74360

Attach all invoices or contract estimates to the reverse side of this jacket. Multiple invoices or contract estimates may be attached provided they are to the same vendor and against the same contract, purchase or authorization order.

Each invoice must show on its face, the signature of the person who received and checked the merchandise. Contractor estimates must be approved by the architect or engineer in charge of the project. Receiving reports may be submitted in lieu of signed invoices.

Vendors should file three copies of each invoice with the Department, Institution, or Agency upon delivery of merchandise.

I hereby approve this claim for payment and certify it complies with the purchasing laws of the State.

Agency's Approving Officer

Title

03/20/2002
Date

Agency, Bd or Div. Use

Picher-Cardin Public Schools
P.O. Box 280
715 West "A: Street
Picher, OK 74360

INVOICE

RECEIVED
2002 MAR 15 P 1:49
FINANCIAL MANAGEMENT

Bill To:	Remit To:
OKLA. STATE DEPT. OF HEALTH Procurement-Contracts Unit 1000 N.E. 10TH STREET OKLAHOMA CITY, OKLAHOMA 73117-1299	PICHER-CARDIN PUBLIC SCHOOL P.O. BOX 280 PICHER, OK 74360 FEI #: 736021187A

Invoice Date: 3/1/02
Billing Period: 2/1/02 - 2/28/02
Purchase Order #: Y032174

Contractor Representative:
Bob Walker, Superintendent
918-673-1714

Item	Quantity	Unit	Description	Unit Price (salary + fringes)	Amount
001	130.5	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	13.46	1,756.53
001	144	Hour	Teachers Aide - reading and math activities, speech language remediation, and lead poisoning prevention curriculum	9.03	1,300.32
				Total Amount	$3,056.85

Y032174 PURCHASE DOCUMENT
COMPLETE 005 PARTIAL
35665 SUB ACTIVITY
MATH ENTERED
INVOICE APPROVED
00023544.97 ACCOUNT NO
4WBT22
5511A-X
3/15/02

Total number of students served during this billing period: 450

Copies of Time and Effort sheets that reflect each duty as an activity code: attached

Time And Effort Cost
Cost Accumulation Schedule

June 13, 2003
Prepared By _____

Prog Cost Period: 10/2001 TO 03/2002
Program Code: 391

==ProgCost==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200110	85.29	186.98	0.21	845.04
200111	36.34	173.01	0.00	594.83
200112	79.59	117.27	0.00	870.41
200201	72.04	99.81	0.00	806.32
200202	59.00	75.58	0.00	590.28
200203	61.32	52.79	0.00	690.10
Total	**393.58**	**705.44**	**0.21**	**4,396.98**

==244Other==

FEES	TRAVEL	EQUIP	OTHER
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00
0.00	**0.00**	**0.00**	**0.00**

==301OTHER==

Year\Month	FEES	TRAVEL	EQUIP	OTHER
200110	12.25	26.85	0.03	121.32
200111	4.08	19.40	0.00	66.71
200112	9.16	13.50	0.00	100.21
200201	8.61	11.93	0.00	96.35
200202	7.05	9.03	0.00	70.52
200203	7.40	6.37	0.00	83.27
Total	**48.55**	**87.08**	**0.03**	**538.38**

==TOTAL==

FEES	TRAVEL	EQUIP	OTHER
97.54	213.83	0.24	966.36
40.42	192.41	0.00	661.54
88.75	130.77	0.00	970.62
80.65	111.74	0.00	902.67
66.05	84.61	0.00	660.80
68.72	59.16	0.00	773.37
442.13	**792.52**	**0.24**	**4,935.36**

Worker's Comp
09/29/2001 to 03/31/2002

FUND	OBJ CODE	REF #	AMOUNT
400BT22	1231	F13234	0.93
400BT22	1231	F18791	1.29
400BT22	1231	F24241	0.93
400BT22	1231	F29721	0.91
400BT22	1231	F13281	2.24
400BT22	1231	F18812	2.25
400BT22	1231	F24261	2.25
400BT22	1231	F29746	2.24
400BT22	1231	F13669	5.88
400BT22	1231	F19020	5.88
400BT22	1231	F24442	5.88
400BT22	1231	F29959	5.86
400BT22	1231	F14852	6.78
400BT22	1231	F19654	6.78
400BT22	1231	F24988	7.80
400BT22	1231	F30601	6.76
400BT22	1231	F17585	3.09
400BT22	1231	F21117	3.09
400BT22	1231	F26273	3.09
400BT22	1231	F32087	3.08
	Total Worker's Comp		**$ 77.01**

INDIRECT COST SCHEDULE

10/2001 TO 03/2002

		SALARY	RATE	TOTAL
SFY 2002				
	On-Site	2,441.85	35.00 %	854.65
	Off-Site	53,747.41	14.00 %	7,524.64
SFY 2002				
	On-Site	0.00	35.00 %	0.00
	Off-Site	0.00	14.00 %	0.00
			Total Indirect Cost	8,379.29

PERSONAL IDENTIFIER(S) REDACTED

STATE AND LOCAL RATE AGREEMENT

EIN #: 1736017987C4

DATE: August 1, 2001

DEPARTMENT/AGENCY:
Oklahoma State Department of Health
P.O. Box 53551
1000 NE Tenth St.
Oklahoma City OK 73117-1299

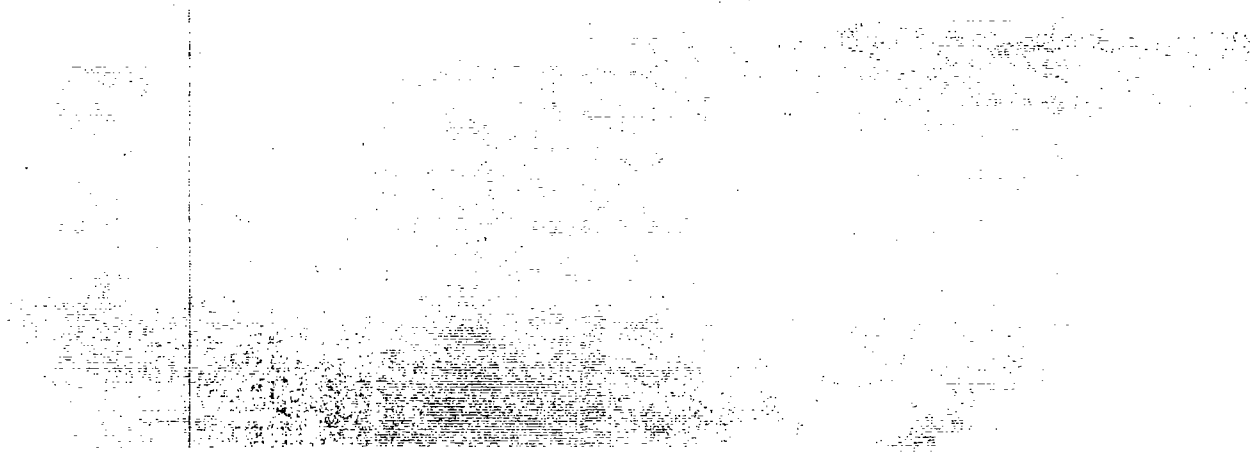
FILING REF.: The preced
Agreement was dated
May 31, 2000

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV. (PROVISIONAL) PRED. (PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE (%)	LOCATIONS	APPLICABLE TO
FIXED	07/01/01	06/30/02	35.0	On Site	All Programs
FIXED	07/01/01	06/30/02	14.0	Off Site	All Programs
PROV.	07/01/02	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending June 30, 2002.		

*BASE:
Direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits.

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