NIAGARA COUNTY
LOCKPORT, NEW YORK 14094

Remit To _____ Charge to Dept Niagara County Dept of Health - CWSN

Address _____

_____

INVOICE NUMBER	INVOICE DATE	DESCRIPTION	AMOUNT
		Total	

I, _____ pursuant to the provisions of Sections 369 of the County Law of the State of New York, certify that the above account in the amount of _____ is true and correct; that the items, services and disbursements charged were actually delivered or rendered to or for the County of Niagara on the dates stated; that the prices charged therefore are reasonable and just, that no perquisites, commissions or allowances of any kind, other than as stated in the said account, have been or will be paid directly or indirectly, in consideration of the procurement of said items or services; that no part has been paid or satisfied; that taxes, from which the County is exempt, are not included; and that the amount claimed is actually due.

_____ _____

CLAIMANT'S SIGNATURE DATE