

MEDICAL EXPENSE REIMBURSEMENT

NAME: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

I hereby request reimbursement for medical expenses. I have attached receipts for those expenses, which I have incurred and paid in full, and I certify that these expenses were incurred for myself or my dependents.

TOTAL RECEIPTS ATTACHED: \$ \_\_\_\_\_

\_\_\_\_\_  
Signature

\*\*\*\*\*

Supervisor's Approval:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

ACCOUNT TO BE CHARGED: \_\_\_\_\_

\*\*\*\*\*

FOR TREASURER'S OFFICE USE:

VENDOR NO.: \_\_\_\_\_

CAP \_\_\_\_\_

PRIOR REIMBURSEMENT: \$ \_\_\_\_\_

THIS REQUEST: \$ \_\_\_\_\_

TOTAL REIMBURSEMENT: \$ \_\_\_\_\_