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: $ _____