

HEALTH CARE EXPENSE REIMBURSEMENT PROGRAM CLAIM FORM

EMPLOYEE NAME:

(Please Print)

ADDRESS:

(Please Print)

BUILDING LOCATION:

DATE:

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EMPLOYEE SIGNATURE

Employer completes this area.

Amount of Reimbursement:

Reimbursement Date:

Approved by:

Account Code: 10.18.000000.3.4562.000.9.000.000