MORTON
UNIT SCHOOL DISTRICT 709

HEALTH CARE EXPENSE REIMBURSEMENT PROGRAM CLAIM FORM

EMPLOYEE NAME:

ADDRESS:

SELECT BUILDING:
District Office

DATE:

EMPLOYEE SIGNATURE:

Employer completes this area.

Amount of Reimbursement:_____

Reimbursement Date:_____

Approved by:_____

Account Code:_**10.0000.3.4562.000.09.000.000**_____