**DAY CARE REIMBURSEMENT FORM**

Staff Name:

Address:

Phone:

Reimbursement being requested:

Dates of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Care Provider Signature:

Day Care Provider Name:

Day Care Provider Phone Number:

By signing this form, I am confirming that the above information is true and I have not received nor will I seek reimbursement for this expense by any other means including my employer’s Section 125 Cafeteria Plan.

Signature of Staff/Grantee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_