MORTON
UNIT SCHOOL DISTRICT 709

HEALTH CARE EXPENSE REIMBURSEMENT PROGRAM CLAIM FORM

EMPLOYEE NAME:

ADDRESS:

SELECT BUILDING: Jefferson Elementary School

DATE:

EMPLOYEE SIGNATURE:

Employer completes this area.

Amount of Reimbursement:_____

Reimbursement Date:_____

Approved by:_____

Account Code: 10.18.000000.3.4562.000.9.000.000