CHILD CARE REIMBURSEMENT FORM

Employee Name:

Program:

Child's Name:

Period of Service: From ____ To _____

Amount received for above period:

Name of Provider:

Address:

Phone Number:

I, as the provider certify that the above stated monies were received by me for the above stated services.

Signature of Provider: _____

I, as the employee certify that the above stated monies were paid by me for the above stated services.

Signature of Employee:_____
Date Submitted:_____

Signature of Program Manager: _____
Date Submitted:_____

Date Received by Administration:_____