WASHTENAW COMMUNITY COLLEGE
Office of Human Resource Management

Faculty
Request for College Provided Reimbursement
(Dental, Vision & Health Club Dues)

Employee ID: @_________________

Employee Name:____
Last First M.I.

Position: ____

Department: ____

Amount of reimbursement: $ ______________________________

I hereby certify that on (date)__________________, I received and paid

the attached medical bill from (provider's name) _

____

____ _______________________
Employee's Signature ***Date***

Notes: ____

____

____

College Reimbursement is for period effective for the academic year 8/16 through 8/15.

All form(s) & supporting document(s) must be in HRM no later than 8/31.

Human Resource Use Only

Processed to Payroll by: ____

Date: ______________________________

Total cost of services: ______________________________

Reimbursement: ______________________________