Revised 1/09

OPTICAL EXPENSE REIMBURSEMENT

Date: _____

Employee Name: _____

Address: _____

_____

Amount of Reimbursement: _____

Date(s) of Service: _____

Optometrist's Name: _____

Address: _____

_____

Phone Number: _____

Attach a copy of the itemized bill for all services performed.

I certify that the optical expenses on the attached bill were for services performed on me or a member of my immediate family.

_____

Employee Signature

Treasurer's Office Review by: _____

Date reviewed: _____