



Health/Wellness Program *Reimbursement Form*

District Name:	Application Date:	
District Contact	Email address	Phone
Request for reimbursement for the following items:	Cost	
TOTAL REQUESTED:		
START-UP FUNDS RECEIVED:		
TOTAL FUNDS AVAILABLE TO DISTRICT:		
Submitted by:	Signature:	
Approved by:	Signature:	
Date Payment Made	Amount of Check Mailed to District:	