Reimbursement/check Request- Enders Road HSA

***All check requests must be made 5 days in advance
***All reimbursement requests must include receipts

YOUR NAME:	**PHONE:**
PROJECT/CATEGORY:	
DATE SUBMITTED TO HSA:	**DATE NEEDED:**
REASON FOR REIMBURSEMENT:	
CHECK PAYABLE TO:	**AMOUNT:**
FULL ADDRESS (your check will be mailed to you):	

Receipt(s) totaling the amount of reimbursement must be included.

APPROVED BY (HSA Treasurer):	DATE:
APPROVED BY (HSA OFFICER if over $500):	DATE:

FOR TREASURER'S USE ONLY:

Category _____ Check # _____ Date _____