UNIVERSITY OF ST. THOMAS
DEPENDENT CARE
REIMBURSEMENT REQUEST

Employee No:	**Name:**
Social Security No:	
Hold Check ☐	**Mail Check** ☐ **Mailing Address:** _____ _____

The following expenses are submitted for reimbursement from my Dependent Care Reimbursement Account for the plan year starting _____, 20 _____. ORIGINAL RECEIPTS and any other pertinent documentation are attached.

Provider Name: _____ **Provider Tax I.D:** _____ **Provider Address:** _____ _____ **AMOUNT :** _____ **Date(s) of service :** _____	**Name(s) of Dependent(s)** : _____ _____ _____ _____ _____

I certify that the above listed items are for reimbursable dependent care expenses paid during the plan year indicated above, are not eligible for reimbursement from any other sources, have not been previously claimed for reimbursement from my child care reimbursement account, and will not be claimed as an income tax deduction.

Employee Signature: _____ **Date:** _____

APPROVED:	**DATE:**
AMOUNT:	**REMAINING:**
CHARGE TO: 221100-100-00000	