DIOCESE OF FORT WAYNE – SOUTH BEND

915 SOUTH CLINTON STREET • P.O. BOX 390 • (260) 422-4611
FORT WAYNE, INDIANA 46801

Reimbursement Account Voucher

Employee Name_____ **Employee S.S. #**_____

Address_____ **Phone #**_____

_____ **Location Name:**_____

Date of Service	Service Provided By	Description of Service	Amount Incurred	Office Use

This is to certify that I have incurred expenses totaled above that qualify for reimbursement

I further certify that I have enclosed documentation so substantiate the above amounts. I understand and agree that since these expenses are to be reimbursed, they man not be claimed for income tax purposes. **The medical expenses listed above are not eligible for and have not been reimbursed by an insurance plan.**	**YOU MUST SIGN AND ELCLOSE RECEIPTS** **Dependent Care Provider I.D.** _____ **Social Security or Day Care Center Employer D.D. Required by IRS** **Employee Signature**_____ **Date**_____