REIMBURSEMENT REQUEST

Date: ____________________

Cardinal School
4045 Ashland Road
Eldon, IA 52554
641-652-7531
Fax 641-652-3143

Name: ____

Position: ____

All receipts must be attached in order to receive a reimbursement. Most reimbursement forms must be processed through the next monthly school board meeting before reimbursement will be given.

AMOUNT	PAY TO: LIST COMPLETE NAME AND ADDRESS	REASON FOR CHECK REQUEST

(Account Numbers/For office use only)

Principal Signature: ____

Superintendent Signature: ____