Small Group Childcare Reimbursement Form

Name _____

Address _____

City _____State_____Zip_____

Phone _____

Check will be made out to the above and mailed to this address

Name of Small Group _____

Date of Meeting	**Number of Hours** 2.0 hours max	**Name of Childcare Provider**	**Cost** $10 per hour
		TOTAL REIMBURSEMENT REQUESTED **(For Acct # 65025)**	

Signature: _____