Caledonia Area Public Schools

Independent School District 299 Caledonia, MN 55921

Reimbursement Request Form

Pay To: _____

Mailing Address: _____

Cell Phone/Landline Phone Number: _____

PLEASE ATTACH ALL PAYMENT RECEIPTS TO THIS FORM

Date	Explanation	Amount	Account Code

TOTAL CLAIM **$** _____

I declare under the penalties of perjury that the above claim is for services performed and none of the above claim has been paid.

Please submit this form to the District Office after obtaining proper approval. Attach all receipts. Please note that sales tax will not be reimbursed.

Requests submitted to the District Office by the 10th of each month will be reimbursed with the 25th payroll or following the meeting of the School Board's approval of bills due and payable.

Claimant/Employee Signature: _____ Date: _____

Administrator Approval: _____ Date: _____

Denial By: _____ Date: _____