

**HAMDEN BOARD OF EDUCATION
Medical Expense Reimbursement Plan
Application for Reimbursement**

Employee Name: _____

Amount of Reimbursement: _____

Please attach itemized statements from the Provider showing amount, date, and nature of expense, including person(s) expense is for, accompanied by receipts, cancelled checks, or other statements showing method and date of payments, if necessary.

I hereby certify that the above listed Medical Expense has not been (and shall not be) reimbursed from any other source, and have not been (and shall not be) used by the Participant (or his/her spouse or Dependent) in determining a credit, including but not limited to section 21 of the Code, toward his/her federal income tax liability.

Signature of Employee

Date