



Palisades Park School District

Vision Expense Reimbursement Form

Employee Legal Name: _____

School or Department: _____

Email: _____

Phone: _____

Please list the individuals for whom you are requesting reimbursement (maximum reimbursement: \$200 per covered individual, up to \$264 per family annually).

Name of Individual	Relationship	Date of Service	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Total Amount Requested: \$ _____ (Maximum \$264 per family)

To process your reimbursement, please attach the following:

- Paid itemized receipt that clearly shows:
 - a. Provider/vendor name
 - b. Date of service
 - c. Description of expenses (e.g. glasses, lenses, contacts)
 - d. Amount paid

Employee Signature: _____ **Date:** _____

For District Use Only

Date Received: _____

Documentation Attached: yes _____ no _____

Approved Amount: \$ _____