



Public Schools of the Tarrytowns

OPTICAL REIMBURSEMENT CLAIM FORM

EMPLOYEE: _____

Date: _____

ADDRESS: _____

TRANSACTION DATE	TYPE OF PURCHASE *(Attach all itemized original receipts)*	TAT , Confidential	CSEA Unit I	CSEA Unit II	EXPENSE AMOUNT
TOTALS:					

TAT / Confidential

\$200 Per Claim

\$200 Maximum Claim Per Year

EMPLOYEE SIGNATURE: _____

CSEA Unit I

\$200 Per Claim

\$200 Maximum Claim Per Year

CSEA Unit II

\$200 Per Claim

\$200 Maximum Claim Per Year

FOR BENEFITS OFFICE USE ONLY

Budget Code: A 9089-802-00-0000

BENEFITS OFFICE APPROVAL: _____ Date: _____

Claim 1 of 2:

Claim 2 of 2:
