

Mount Clemens Montessori Academy

# PARENT GUILD



## Reimbursement Request

Your Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date Submitted: \_\_\_\_\_

Check Payable to: \_\_\_\_\_

Full Address: \_\_\_\_\_

Your check will be mailed at the above address.

Date must be paid by: \_\_\_\_\_

Project/Category: \_\_\_\_\_ Amount \$ \_\_\_\_\_

Reason for Reimbursement: \_\_\_\_\_

Included in annual budget ..... Or .....  Approved at meeting (date \_\_\_\_\_)

Receipt(s) totaling the amount of reimbursement must be attached (or no check will be submitted).

Approved by (PG Officer) \_\_\_\_\_ Date: \_\_\_\_\_

Approved by (PG Officer) \_\_\_\_\_ Date: \_\_\_\_\_



For Treasurer's Use Only

Category \_\_\_\_\_ Check # \_\_\_\_\_ Dated \_\_\_\_\_ Logged