

**REQUEST FOR REINBURSEMENT/PAYMENT OF EXPENSES**

Submitted By: (Print Name) \_\_\_\_\_ Date \_\_\_\_\_

Signature: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Committee: \_\_\_\_\_

Committee Chair Signature: \_\_\_\_\_

Payable To: (Name) \_\_\_\_\_

Send Check To: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nature/Purpose of Expense: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

AMOUNT \$ \_\_\_\_\_

RECEIPTS/INVOICES ARE REQUIRED. Please return this form with all required signatures and documentation to:

Florence LaCroix  
Director of Financial Aid  
Bridgeport Hospital School of Nursing  
200 Mill Hill Avenue  
Bridgeport, CT 06610

Phone: (203) 384-3202  
Fax: (203) 384-3046

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**TREASURER APPROVAL**

Budgeted Expense: YES \_\_\_\_\_ NO \_\_\_\_\_

Check #: \_\_\_\_\_ Date: \_\_\_\_\_ Expense Acct. #: \_\_\_\_\_

Treasurer's Signature: \_\_\_\_\_