

CAPFAA

REQUEST FOR REIMBURSEMENT/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

TREASURER APPROVAL

Budgeted Expense: YES _____ NO _____

Check #: _____ Date: _____ Expense Acct. #: _____

Treasurer's Signature: _____