Ref. #: .278(A) .281(R)

Amount Due: $_____

Approved by: _____

Franklin County Technical School
Medical Reimbursement Form

Member Name: _____

Office co-pay reimbursement: $5.00 or the full cost of your co-pay if scheduled after working day (receipt must show time of appointment to verify) Attached receipts to this form.

	Date of visit	**Amount Due**
Date of office visit	_____	_____
Date of office visit	_____	_____
Date of office visit	_____	_____
Date of office visit	_____	_____
Date of office visit	_____	_____
Date of office visit	_____	_____
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Date of office visit	_____	_____
Date of office visit	_____	_____
Date of office visit	_____	_____
Date of office visit	_____	_____
Date of office visit	_____	_____
	Total Due	_____