

# Medical Expense Reimbursement Form

Employee Name

Employee ID

Department

Date of Submission

Expense Details

Date	Provider/Clinic	Description	Amount
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<div></div>	<div></div>	<div></div>	<div></div>
<div></div>	<div></div>	<div></div>	<div></div>

Total Amount

Additional Notes

Employee Signature

Date Signed