

Healthcare Worker Uniform Reimbursement Form

Employee Name

Department

Employee ID

Date of Request

Manager/Supervisor Name

Uniform Items

Item Description	Vendor	Date Purchased	Amount
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Total Amount

Notes

Employee Signature

Date

Manager Approval

Date