CITY OF CHICO

FITNESS FACILITY REIMBURSEMENT REQUEST

CPOA

Name:
Amount requested: *SINGLE* Monthly Rate = $ _____ x _____ Months = *TOTAL* $ _____
Please process a reimbursement for the following period (6-month increments) for my fitness facility benefit: *(submit within 90 days of the end of the period)* ❑ January – June *(submit by Sept 30)* ❑ July – December *(submit by March 31)*
Name of fitness facility:

As specified in the MOU, be sure to attach proof of payment.

_____ _____

Signature Date

Please print Reimbursement Request on pink paper.

For HR/Payroll Use		
Amount approved:	By:	Pay period:
Notes:		