☐ General

☐ Welfare

**Name:** _____ **Date:** _____

**Purpose of Expense:** _____

_____

| Date | Vendor | Description | Category | Cost |
|---|---|---|---|---|
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| **Total Reimbursement** | | | | **$** |
| ****Request for reimbursement must be submitted within 45 days** Itemized receipt(s) must be attached.** | | | | |

Reimbursement Member Signature

Approval Signature – KSC Executive Board Member

**Check Number:** _____ **Check Date:** _____

# KSC Reimbursement Form