Strong Family Health Center Youth Sports/Activity Reimbursement Program Application

Youth Client Name:

_____

DOB: _____ AGE: _____

School: _____

GPA: _____ ***Attach copy of most current grades**

Name of Organized Program/Activity:

_____

Name of Instructor/Coach: _____

Instructor's Contact Phone Number: _____

Amount Requested: $_____ $150 is max reimbursement available.

What was purchased or paid for?

_____

_____

***Attach a copy of your receipt; request must be no more than 30 calendar days after date of purchase.**

Reimbursement check will be written to;

Name: _____

Address: _____

Requestors Name: _____ Date: _____
Please Print

Requestors Signature: _____