



CINCINNATI CHILDREN'S
FAMILY ADVISORY COUNCIL REIMBURSEMENT

change the outcome®

NAME: _____ SS# _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

*NAME OF MEETING OR COMMITTEE: _____

DATE OF MEETING: _____

REASON FOR REQUEST:

Child Care: Number of hours: _____
 Amount per hour: \$ _____
 Total: \$ _____

Transportation: Round-trip mileage: _____

COMMENTS:

* This form may be used for any committee or task force you attend as a representative of the **Family Advisory Council**.

Please mail to:
Karen Schulte
Family Resource Center, ML 3007
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue
Cincinnati, Ohio 45229

Office Use Only:

Date received: _____

Approved: _____

Total: \$ _____