



VISION REIMBURSEMENT FORM

Employee Name: _____ Site: _____

Check One: Certificated Classified

Vision Expenses Submitted: \$ _____ Date Submitted: _____

Employee Signature: _____ Date: _____

Please complete this form, attach all original receipts, and submit to:

SVUSD BUSINESS DEPARTMENT

RE: VISION REIMBURSEMENT

17850 Railroad Avenue, Sonoma, CA 95476

FOR BUSINESS OFFICE ONLY:

Account Codes:

01-0000-0-1110-1000-3441-000-0105 (Certificated)

01-0000-0-1110-1000-3442-000-0105 (Classified)

Amount Due to Employee: \$ _____ Date Processed: _____

Approval Signature: _____ Date: _____