Sonoma Valley Unified School District

VISION REIMBURSEMENT FORM

Employee Name: _____ Site: _____

Check One: ___ Certificated -OR- ___ Classified

Vision Expenses Submitted: $ _____ Date Submitted: _____

Employee's 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:

_____

_____

_____

Amount Due to Employee: $ _____ Date Processed: _____

Approval Signature: _____ Date: _____