REIMBURSEMENT REQUEST FOR WELLNESS INITIATIVE

Submit this form on the same schedule as your monthly mileage forms are submitted.

Employee Name: _____ *For Period from _____ to _____

Program: _____ Work Site Name: _____

County Where You Work: _____(For GAHS) _____-_____-_____
Dept # Project Code Site Code

ACTIVITY/CENTER INFORMATION

Name of Fitness/Weight Loss Center or Activity Used: _____

Phone # _(_____)__ _____

Address: _____
Street Address City State Zip Code

How much is your total monthly fee?: _____*(attach documentation for first time verifying monthly fee)*

PAYMENT VERIFICATION

Date of Receipt _____ Amount Paid _____

Verification of Payment *(Check one of the following and attach receipt to this request form)*

_____ Monthly Receipt _____ Monthly Bank Draft

_____ Annual Membership Receipt *(attach 1st month only – receipt will be kept on file)*

For annual membership, indicate dates of contract: _____ to _____

In order to be eligible to be reimbursed for up to $25 per month, the employee must participate in an eligible activity at least 8 sessions per month of at least 45 minutes duration each time OR 12 sessions per month of at least 30 minutes duration each time. [**NOTE:** There is one exception. If an employee has a serious illness or injury and the employee's physician provides a note saying the employee cannot exercise at all (not even light exercise), then the employee may be temporarily excused from participation. The excused period shall not exceed a maximum of 2 months during a 12 month calendar year. The employee will need to attach both a receipt **and** a doctor's note to this form.

DATE (mo/day/yr)	ACTIVITY LOCATION OR TYPE OF ACTIVITY	TIME (start time to end time)	TOTAL MINUTES
		to	
		to	
		to	
		to	
		to	
		to	
		to	
		to	
		to	
		to	
		to	
		to	

In signing below, I certify that the above information is correct and true. I understand that submitting a request for reimbursement for activities for which I did not attend as indicated is considered fraud.

Employee Signature: _____ **Date:** _____

*Use same time period as Mileage Claim Form J:\FORMS\Reimbursement Request for Wellness Program-05-13-08.doc

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