AMERICAN LEGION AUXILIARY ~ DEPARTMENT OF FLORIDA, INC.
P.O. BOX 547917- ORLANDO, FL. 32854-7917

MEDICAL CENTER REPRESENTATIVES
REIMBURSEMENT / RELEASE OF FUNDS REQUEST

DATE:_____

FACILITY:_____ REPRESENTATIVE/DEPUTY:_____

***Choose all applicable*:**

_____ **Please send a reimbursement** in the amount of $_____ for the purchase of the items on the attached receipts, spent for purpose(s) of: _____

Check is to be payable to: _____

Mailed to:_____

_____ **Please approve purchase of** $_____ for the purpose of

_____ .

I am seeking approval for these items due to: (Check all that apply)
____Single item purchase of over $750

____Special consideration for a purchase from "General VMAC Needs Account" because all available funds to my facility have been exhausted

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_____ **Please transfer** $_____ from my savings to my checking for the purpose of

_____ .

_____ **Please release funds** (i.e. send a check) in the amount of _____ for the purpose of _____ .

*Check is to be payable to: _____

Mailed to:_____

***RECEIPTS MUST BE MAILED TO DEPARTMENT WITHIN 30 (THIRTY) DAYS.**

Updated 07/2017