City of Chico

FITNESS REIMBURSEMENT REQUEST

Name:
Amount requested: SINGLE monthly rate* = $_____ x _____ months = TOTAL $_____ (*limit: CPOA, CPM, IAFF - $50.00/month; CFME - $55.00/month) Bargaining Unit: ☐ CPOA ☐ CPM ☐ IAFF ☐ CFME
Please process a reimbursement for the following period (6-month increments) for my fitness benefit: *(submit within 90 days of the end of the designated period)* ☐ January – June (submit by Sept 30) ☐ July – December (submit by March 31)
Name of facility:

Be sure to attach proof of payment.
Your proof must include (1) the payee's name and (2) month/day/year of payment.
If submitting digital images, please embed them in a PDF file – do not send picture (JPG) files.
WE APPRECIATE YOUR ASSISTANCE.

Submitted by: _____ Date: _____

For HR/Payroll Use		
Amount approved:	By:	Pay Period:
Notes:		