CITY OF CHICO
FITNESS FACILITY REIMBURSEMENT REQUEST

IAFF / CBC / PSM

Name: _____
Please process a reimbursement for the listed months for my fitness facility benefit (maximum of three months): Amount requested: Month 1: _____ $_____ Month 2: _____ $_____ Month 3: _____ $_____ TOTAL $_____
Name of fitness facility: _____

As specified in the MOU, be sure to attach written proof of participation & payment of dues and submit to Human Resources within 90 days following the end of the coverage period.

_____ _____

Signature *Date*

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