

Coach Clinic Reimbursement Form



Name:

Address:

Team:

Position:

Date:

*head coach 100%, assistant 50%

Email completed form to treasurer@egha.ab.ca

Clinic Information

Date Completed	Clinic Description	Certificate Number	COST
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TOTAL REIMBURSEMENT			<input type="text"/>

Don't forget to attach receipts!

Signature Date

Division Director Approval Date

For Treasurer Use Only

Cheque Date:

Reimbursement Cheque #:

