

Wellness Program Fitness Reimbursement Request

This request is for: employee
 insured spouse
 insured dependent

Employee's Department _____

Employee's name (required): _____

Spouse's/Dependent's name (if applicable): _____

A separate form and documentation must be submitted for each requestor seeking reimbursement.

	<i>Filled out by Requestor</i>			<i>Admin Use Only</i>	
	Year	Month	No. of Visits	Amount	Approved
Month 1					
Month 2					
Month 3					
Month 4					
Month 5					
Month 6					

Documentation confirming the number of visits to a fitness facility by the Requestor must accompany this form.

I understand that this request is subject to the provisions of the latest program guidelines and to the availability of program funding.

Requestor Signature: _____ **Date:** _____

Send completed form to:
 Human Resources
 5 West Main Street, Suite 200
 Fincastle, VA 24090
 Fax: (540) 928-2001
 Email: hr@botetourtva.gov

Admin Use Only

Reviewed by: _____ Date: _____

Reason if denied: _____

Admin authorization: _____ Date: _____

Total approved reimbursement: _____ Acct #: 100-4091000-91000-2450-000