EXHIBIT 8

Athletic Center Reimbursement Form

The Wellness Program is open to all full-time employees and regular part-time employees averaging 20 hours or more after one year of service, and spouses.

Employee Name: ____

Reimbursement Request:

☐ $15/month – Single Membership ☐ $25/month – Family Membership

If monthly membership fee is less than what is listed above, list dollar amount here: _________________

Coverage Dates: Ie. 1/1/19 – 1/31/19	Wellness Facility/Program Name

Must attach a receipt of payment or a bank statement (you may black out other information on the bank statement). In order for the claim to be eligible for reimbursement, this form must be received by Accounts Payable with 60 days of the date of payment.

I certify that the information on this form and all supporting documents are complete, accurate and unaltered.

____ _______________

Employee Signature Date

For Department Head Use Only:

Approved ☐ Denied ☐ Reason for denial: ____

____ ____________________

Department Head Signature Date

____

Account Code