DATE _____

SAN LUIS OBISPO COUNTY COMMUNITY COLLEGE DISTRICT

P.O. Box 8106

San Luis Obispo, California 93403-8106

Tuition Reimbursement CLAIM

CCCUE 4606

CLAIMANT _____

ADDRESS _____

_____

Semester to be reimbursed _____

EMPLOYEE ID _

	AMOUNT

Please attached receipt of paid classes and copy of passing grade.

Total $ 0.00

CERTIFICATE OF CLAIMANT:

I hereby certify that the above claim and the items, amounts and statements are true and correct.

_____ _____

Signature of Claimant Treasurer Approval