Health & Wellness

APPLICATION FOR REIMBURSEMENT OF EYE EXAMINATION FOR NYPA UWUA BARGAINING UNIT EMPLOYEES

TO: Human Resources Facility Manager

DATE: _____

FROM: _____
Employee Name (Print)

DATE OF LAST EXAM: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

SITE FINANCE MANAGER
SIGNATURE: _____ DATE: _____

G/L ACCT# 631700
COST CTR H129

A bill signed by a licensed ophthalmologist or optometrist including the employee's name, date of service, cost, and description of services must be attached.

TO: SENIOR ACCOUNTANT/PAYROLL

ACCOUNTING SIGNATURE: _____ DATE: _____

AMOUNT TO BE REIMBURSED: _____

Employee to be reimbursed through payroll.