REIMBURSEMENT REQUEST

Congregation Beth Israel Sisterhood

Date Submitted: _____

Payable to: _____

Name: _____

Street: _____

City: _____ Zip: _____

Email: _____ Phone: _____

☐ Mail ☐ Pick up at CBI

Program Name: _____

Description of Item/Services	Amount
	$
	$
	$
	$
	$
	$
Total	**$**

☐ In-Kind Donation

☐ Reimbursement Requested

Receipts/Invoice must be attached. All information must be filled out in order to receive a check. Please allow at least 5 days for pickup or 2 weeks for checks to be mailed.

For office use only

Approved by: _____

Date Paid: _____

Check Number: _____