CBSA
DEPENDENT/CHILD CARE RECEIPT

EMPLOYER: ________________________________ DAYTIME PHONE #: ( ) ________________________

NAME: ____________________________________ SOCIAL SECURITY #: _

Name of Day Care Provider	Dates of From	Service To	Dependent's Name	Dep's Age	Amount to Be Reimbursed
					$
					$
					$
					$

Total amount requested from your account: $ ________

Provider's Signature ________________________________ Provider's SS# or Tax ID# ____________________

I certify that the above information is correct and complete.

____ ________________________

EMPLOYEE'S SIGNATURE DATE