DEPENDENT CARE RECEIPT for FLEX PLAN REIMBURSEMENT

DATE: _____

RECEIVED PAYMENT FROM (Parent/Guardian Name)**:** _____

CHILD(REN) NAME: _____

DATES OF SERVICE: _____ **TO** _____
Month/Day/Year Month/Day/Year

CHARGES: $_____

DAYCARE PROVIDER SIGNATURE (Required as proof of payment)**:** _____

DAYCARE PROVIDER SOCIAL SECURITY OR TAX ID NUMBER: _____

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