

Adoption Assistance Reimbursement Request Form

Employee Information:		
Employee Name	ID Number	Bargaining Unit
Department	Job Title	
Home Address		
City	State	Zip Code
Home Phone	Work Phone	
Eligible Adoption Expens	es:	
Date Paid	Amount	Description
	_	
Total Reimbursement:		
Note: *Please attach receipts in U.S. dollars for all expenses listed above, as well as a copy of the adoption placement decree. *Applicable federal, state and local taxes will be withheld from your reimbursement.		
Employee Request for Reimbursement:		
I would like to apply for reimbursemen	nt of adoption expenses listed above, cor (Child's name)	nfirming that
Whose birth date is, was placed in my home for the purpose of adoption on(Date)		
I certify that this is a claim for allowable expenses under the University of Massachusetts Medical School adoption reimbursement program.		
(Signature of employee)		(Date)
(Approved)		(Date)