



South End Fitness Center

A Division of the Boston Public Health Commission



MEMBER REIMBURSEMENT FORM

Member and Expense Information (Please Print):

Date of Request: _____

Member Name: _____ Member Number: _____

Address: _____

Daytime Phone #: _____ Evening Phone #: _____

Description and Reason for Refund: _____

Send Check to:

Original Method of Payment (Circle One):

- Check
- Money Order
- Credit Card

Date of Transaction: _____ Amount: _____

Required Authorizations:

Member Signature: _____ **Date:** _____

By signing above I have supplied and verified that all receipts and documentation are valid in supporting reimbursement.

SEFC Management Signature: _____ **Date:** _____

BPHC Administration Approval: **APPROVED / DENIED**

Signature: _____ **Date:** _____

Submit the form to: SEFC / Community Initiatives Bureau
1010 Massachusetts Avenue, 2nd Floor
Boston, Massachusetts 02118
Tel. (617)-534-5965 | Fax. (617) 534-2372