

**COLUMBUS STATE UNIVERSITY**

Request for Dependent Care  
Expense Reimbursement  
for calendar year 200\_\_

Send or mail completed form to:

Human Resources  
Columbus State University  
4225 University Ave  
Columbus, GA 31907



SSN \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
Daytime Phone \_\_\_\_\_

**For each item listed, attach a receipt which includes:**

- \*Name of dependent
- \*Date(s) of service provided
- \*Amount of dependent care expense incurred
- \*Provider Federal ID or SSN
- \*Day care provider's name and telephone number

**For individual providers also include:**

- \*Relationship to employee
- \*Day care provider's signature

Provider of Service	Person receiving service	Relationship to Employee	Birthdate	Date(s) of Service	Reimbursement

You should receive your reimbursement check in approximately 10-14 days.

Total reimbursement

**Certification:**

I hereby certify that the dependent care expenses were incurred by me and that all the information recorded on this request is true and correct. I understand that I have the responsibility for any tax reporting or other legal requirements with respect to reimbursable expenses. I also understand that to the extent dependent care expenses are reimbursed under the Dependent Care Spending Account, they may not be claimed as expenses for purpose of the credit against federal tax for dependent care expenses. Eligible expenses are verified using IRS guidelines.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Approved for Reimbursement \_\_\_\_\_ Date \_\_\_\_\_

This form may be duplicated as needed. Additional forms are available in Human Resources.