

Forest Health Program REQUEST FOR REIMBURSEMENT

Date _____

<p>_____ Community name</p> <p>_____ Street or PO Box Number</p> <p>_____ City / State / Zip</p> <p>_____ Attention: (Person/Department to receive payment)</p>	<p>Date Project Completed _____</p>
<p><u>Expenditures as confirmed in attachments</u></p> <p>A. Number of eligible trees treated _____</p> <p>B. Cumulative DBH inches treated _____</p> <p>C. Total cost for treatment \$ _____</p> <p>D. Amount requested (not to exceed \$16 per treatment inch, up to \$ _____ approved amount</p> <p>E. Percentage of total project cost reimbursed _____ %</p>	<p><u>For NCFS Official Use Only</u></p> <p>Field Confirmation Date _____</p> <p>Payment Approved By: _____</p> <p>Amount: \$ _____</p> <p>Date: _____</p>

Print Name of Authorized Representative

Title of Authorized Representative

Signature of Authorized Representative (sign with **BLUE** ink)

Date