HARDING UNIVERSITY
Dependent Care
Reimbursement Claim Form

Employee Name: ____ SS#: _______-_____-_______

Dependent Name(s): ______________________________________

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Day Care Provider: ______________________________________

Address: ____

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Dates of Service: ________________________________ Through ________________________________

Charge for Service: __________________ Per Hour ________ Per Day _________ Per Week _________

Total Charges: ______________________

Employee Certification

I hereby certify that all items requested to be reimbursed comply with the Harding University Dependent Care Reimbursement Account and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. Harding University does not accept responsibility for direct payment to any individuals other that the employee.

____ _____________
Employee Signature Date