**Medical Students for Choice**

 **Request for Reimbursement**

**School:**

**Name of**

**Payment Recipient:**

*First**Last/Surname*

**Payment Method:** (choose one)

Check\*

Mailing Address:

*Street*

 *City, State/Province Zip Code*

**FOR MSFC STAFF USE ONLY**

DATE APPROVED:

INITIALS:

CLASS:

SPECIAL INSTRUCTIONS:

 PayPal

 PayPal Email:

**Funding Type Request:** (choose all that apply)

Student Activism Fund (semester funding)

 Chapter Trust Account

 Other, explain:

**Date:**

**Amount Requested:**

$

*\*PayPal is recommended to avoid potential check fees.*

**BEFORE SUBMITTING YOUR REQUEST, PLEASE REVIEW:**

* Request is submitted within **30 days** of the date on your receipt.
* All **ITEMIZED** receipts are included with request. (bank/credit card statements are not acceptable)
* Event details are completed below.
* If you are not a student leader, a current student leader must approve your request.
* Submit reimbursement request to **students@msfc.org****.**

**Date of Event: Number of Attendees:**

**Event Topic/Title:**

**Name and Affiliation of Speaker(s):**

**Event Details:**