KANATA MINOR HOCKEY ASSOCIATION

CLINIC REIMBURSEMENT FORM

Please attach proof of purchase for the clinic and along with this form email to info@kmha.ca

A cheque will then be mailed to your home address- Please note, this takes approximately 2 weeks

Please note: All reimbursements requests must be submitted no later than **April 15th, of said hockey year**

NAME

ADDRESS (including postal code)

TEAM NAME

POSTIION ON TEAM

CLINIC NAME

CLINIC DATE

AMOUNT REQUESTED $

FOR OFFICE USE ONLY

AMOUNT	CHEQUE #	DATE