1700 WEST 162nd STREET / GARDENA, CALIFORNIA 90247-3732 / WWW.CITYOFGARDENA.ORG / PHONE (310) 217-9500

Wellness Stipend Reimbursement Form

EMPLOYEE INFORMATION

Full Name (Last, First MI)		**Job Title**	
Department		**Division**	
Address	**City**	**State**	**Zip**
Phone #	**Email**	**Bargaining Unit** ☐ GMEO ☐ Unrepresented	

EXPENSE INFORMATION

Date	Description	Cost
	Total	

By signing this form, I understand:

- **Only qualified expenses are eligible for reimbursement subject to City Manager approval**
- **To be reimbursed I must submit receipts and have funds available within the applicable fiscal year**

Employee Signature _____ **Date** _____

CITY MANAGER/HR OFFICER ACTION

Request

☐ Approved $ _____

☐ Partial Approval $ _____

☐ Denied _____

City Manager/HR Officer Signature _____ **Date** _____