LITCHFIELD SCHOOL DISTRICT

LEA PRESCRIPTION REIMBURSEMENT FORM

Member Name _____

Prescription Date _____ Prescription Cost $ _____

Prescription Date _____ Prescription Cost $ _____

Prescription Date _____ Prescription Cost $ _____

Prescription Date _____ Prescription Cost $ _____

Prescription Date _____ Prescription Cost $ _____

Prescription Date _____ Prescription Cost $ _____

Prescription Date _____ Prescription Cost $ _____

Prescription Date _____ Prescription Cost $ _____

Total $_____

Employee Signature _____

LEA Signature _____