Children's Hospital of Michigan
Family Advisor Reimbursement Form

Name_____
Social Security Number _____
Address _____
City _____ State _____ Zip _____

*Name of Committee or Meeting _____
Date _____ Length of time: From _____ am/ pm to _____ am/pm

I am requesting reimbursement for:
Child Care expenses Number of hours____ X rate of pay $_____ = $_____ total
Transportation: Round trip mileage _____
Other _____

Total amount to be reimbursed $_____

Signature: _____

Please scan, fax or mail to:
Beverly Crider, Director
Family Centered Care
Children's Hospital of Michigan
3901 Beaubien
Detroit, Michigan 48201
Email: BCrider@dmc.org
Fax: 313-993-0389

For office use only:
Date received: _____
Date Approved: _____
Total Amount : _____

* This form may be used for any Children's Hospital of Michigan committee or task force event you attend as a designated CHM Family Advisor. Prior approval is required.