

Triad Challenge League Reimbursement Form

Name	Date
Street Address	City / State / Zip
Home Phone	Work Phone
License Grade	Clinic Attended
Clinic Cost*	Home Association
Signature	
Association Approval	Title
Triad Challenge Approval	Title
Amount Reimbursed	Check Number
*Attach receipts or copy of canceled check. Reimbursement rate is 75% of the cost of the attained license.	