

# OFFICE SUPPLIES REIMBURSEMENT

Payroll Claim Form

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE ID \_\_\_\_\_

DEPARTMENT / COST CENTER \_\_\_\_\_

SUBMISSION DATE \_\_\_\_\_

MANAGER / APPROVER \_\_\_\_\_

PAY PERIOD \_\_\_\_\_

DATE OF PURCHASE	ITEM DESCRIPTION	VENDOR / STORE	RECEIPT ATTACHED	AMOUNT
			<input type="checkbox"/>	
			<input type="checkbox"/>	
			<input type="checkbox"/>	
			<input type="checkbox"/>	
			<input type="checkbox"/>	

Subtotal

Tax

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**Total Reimbursement**

EMPLOYEE SIGNATURE Date: \_\_\_\_\_

MANAGER / SUPERVISOR APPROVAL Date: \_\_\_\_\_

PAYROLL DEPARTMENT APPROVAL Date: \_\_\_\_\_

