Rockingham County Long Term Care

UNIFORM ALLOWANCE

EMP #: AP ____________

Current Information - Please complete for all transactions:

Name: ______________________________ **Dept:** ______________________

Requested Reimbursment - Date: ________________ **Amount:** ______________________

Allowance Rate Basis:

Emp Status - Hours: ________ - biwkly hours Original DOH: __________ Current DOH: ______________

Reviewers Calculations: Anniversary: _____ / _____

Annual Allowance $ __________ Prior Payments $ __________ Payment Due $ __________

Employee Signature: ____________________________________ **Date:** ____________

Approvals:

Dept Mgr/Supvsr ______________________________ ____/____/____

Please attach receipts below or staple to back.

Administration Use:

Approved: ______________

Amount: ______________

Bid ______ **T#** ______________

Acct No. 59001