

Linn County 4-H Horse Leaders Association

Invoice / Reimbursement Request

Name _____ Phone _____

Complete Mailing Address _____

City _____ State _____ Zip _____

Date(s) of Service _____

Please check box and explain expenditure

Reason for payment/reimbursement request:

Clinician Fees for: _____

Other Clinic Expenses for: _____

Awards for: _____

Supplies for: _____

Printing for: _____

Other: _____

Amount to be paid/reimbursed: \$ _____

Signature of requester _____ Date _____

Please attach receipts and mail to:

Linn County Horse Leaders
P.O. Box 154
Lebanon, OR 97355

If the above items are not within the yearly budget or previously approved by the Leaders Association, the reimbursement request will be presented at the next leaders meeting held the 4th Thursday of each month.

Signature of Committee Chairperson (ie clinic, awards, etc) _____ Date _____