



ROSS VALLEY SANITARY DISTRICT

1111 Andersen Drive
San Rafael, CA 94901
(415) 259-2949

Physical Wellness Reimbursement Form

Date Submitted: _____

Employee Name _____

Description of Expense: _____

Date of Expense _____

Expense must be incurred during current fiscal year.

TOTAL REIMBURSEMENT REQUESTED

I attest that the above described expense has been purchased in accordance with the physical wellness reimbursement program. I understand and acknowledge that the intent of the program is to provide a health and wellness reimbursement benefit to employees of Ross Valley Sanitary District.

Employee Signature _____

Manager Approval: _____

Please submit, via email, to cwinnicki@rvsd.org and include all receipts/proof of payment with this form.