**Medical Students for Choice®**

**Request for Reimbursement**

**School:**

**Payment Recipient:**

**Mailing Address:**

*(Street Address)*

*(City, State/Province, Zip Code)*

**Phone number:**

**Select Payment Method**

Check\*

PayPal

PayPal Email:

**Reason for Request**

MSFC Student Activism Fund

MSFC Trust Account Reimbursement

Other, please specify:

**Event Topic/Title:**

**Date of Event: Number of Attendees:**

**Event Details:**

**Name and Affiliation of Speaker(s):**

**Date:**

**Total Amount Requested**

**FOR MSFC STAFF USE ONLY**

DATE APPROVED:

INITIALS:

CLASS:

SPECIAL INSTRUCTIONS:

**BEFORE SUBMITTING YOUR REIMBURSEMENT, PLEASE ENSURE THAT:**

* **Your request is submitted within 30 days of the date on your receipt, and**
* **You include all receipts with this request. ALL RECEIPTS MUST BE ITEMIZED.**

*MSFC does not accept bank or credit card statements.*

*\*Paypal is recommended. If your check does not reach you, you will be responsible for a $33 stop payment fee.*

**If you are not a student leader, please ask a current student leader to approve your request by emailing** [**students@msfc.org**](mailto:students@msfc.org)**.**

Please email reimbursement requests to [students@msfc.org](mailto:students@msfc.org).

Medical Students for Choice ∙ P.O. Box 40935 Philadelphia, PA 19107 USA ∙ Phone: 1-215-625-0800