

PARALYZED VETERANS OF AMERICA - WI CHAPTER'S

FINANCIAL REQUEST FORM

DATE _____/_____/_____

NAME _____

ADDRESS _____

TELEPHONE # (_____) _____ -- _____ EMAIL _____

NAME AND ADDRESS OF EVENT _____

DATE OF EVENT _____ ARRIVAL DATE _____ DEPARTURE _____

DATE _____ ESTIMATED TOTAL AMOUNT OF REIMBURSEMENT REQUEST

\$ _____

BREAKDOWN "ESTIMATE"

AIR FARE \$ _____ MEALS \$ _____ OTHER (SPEC.) \$ _____

MILEAGE _____ LODGING \$ _____

PERSONAL CARE ATTENDENT (PCA) INFORMATION (MANDATORY)

NAME: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER: (_____) _____ -- _____ VA APPROVED CAREGIVER _____ YES _____ NO

PLEDGE & RELEASE OF LIABILITY

I have read and hereby agree to the terms of the PVA-WI's Sports & Travel Policies and Procedures. I understand if I do not complete the requirements, I may not be eligible for future financial assistance from the PVA Wisconsin Chapter until I have complied with the requirements.

If I am receiving additional funding from another source for this event, I am disclosing this information:

Amount: _____ **Source:** _____

SIGNATURE _____ DATE ____/____/____

APPROVING SIGNATURE _____ DATE ____/____/____

OFFICE USE ONLY	
NOVICE	_____
MEMBER/ASSOC MEM.	_____
NOTIFIED	_____
\$\$ APPROVED	_____