Childcare Reimbursement Request

Fellow/Trainee Information

Name:	UK ID:
Email:	Phone:

Grant Information

WBS Element: *	Award # (Sponsor ID):
Appointment Start Date: *	Appointment End Date: *

Childcare Details and Amount Requested

Information about your dependent child(ren) who will be in licensed childcare. If necessary, continue your list on additional page.

Name(s): *	Enroll Dates* (Must be within appointment time frame)	Age: *	Amount/Cost:

Total amount requested (may not exceed $2,500*): * $_____

Licensed Childcare Provider Name	Childcare License Number

Receipt / Proof

I have attached receipt and proof of childcare provider licensing identification. I have read and understand the eligibility and restriction requirements for this payment. I understand my responsibility for retaining the documentation for audit and income tax purposes.

Signature: Date:

Payment Details

- Submit the completed form and supporting documentation to your department administrator.
- The payment will be made in the form of a one-time payment. (IT0015, WT 2580, g/l account 512251)

For more information on NIH requirements for fellowships and training grants please visit:.

* Required Field