DEPENDENT/FAMILY CARE RECEIPT

(To be attached to an Expense Claim Form)

PLEASE PRINT CLEARLY

Date: _____, 20___

Received from _____ the amount of $ _____
(Members' Name)

_____/100 DOLLARS

FOR CHILD/DEPENDENT/FAMILY CARE PROVIDED FOR _____
(Name of child/dependent))

_____ ON _____, 20__.
(Relationship) (Dates)

SIGNED BY: _____ _____
(Caregiver's Signature) (Print Caregiver's Name)

REASON AND TIME FOR CHILD/DEPENDENT/FAMILY CARE PAID FOR ABOVE:

	DATE	REASON/FUNCTION	TIME	AMOUNT
1				
2				
3				
4				

SIGNED BY: _____ _____
(Member's Signature) (Print Member's Name)

IS THE CAREGIVER ABOVE SOMEONE OTHER THAN YOUR PARTNER/SPOUSE? ☐ Yes ☐ No

What would your normal working shift and child/dependent/family care requirements normally have been for the dates listed above? (eg. June 10/13 day shift 8:30 am – 4:30 pm)

1. _____

2. _____

3. _____

DEPENDENT/FAMILY CARE POLICY:
Members/Representatives of the Union are entitled to reimbursement of reasonable receipted costs of dependent/family care provided by someone other than his/her partner/spouse as a result of absence from home arising from the conduct of union business. Such allowance is not intended to reimburse the claimant for dependent/family expenses he/she would normally have incurred as a result of employment except where the absence exceeds the normal work day or week.

/yg: USW 2009