CITY OF OXNARD

MANAGEMENT AND CONFIDENTIAL EMPLOYEES' WELLNESS PROGRAM

MEDICAL EXAMINATION REIMBURSEMENT FORM

TO: Human Resources Director

FROM: _____

TITLE: _____

Department/Division

_____
Employee Number

In accordance with Resolution No. 9256 and the Administrative Manual, I am eligible to receive reimbursement for a medical examination under the provisions of the Management and Confidential Employees' Wellness Program. Attached is an original receipt for the cost of the medical examination. My health insurance plan will pay $_____ of the total cost of the examination: Therefore, I request reimbursement for the balance of $_____.

_____

Date Employee Signature

TO: Payroll

The above request for reimbursement of the cost for a medical examination, as specified in the Management and Confidential Employees' Wellness Program is approved/denied.

Please reimburse the employee $_____

_____ _____

Date Authorized Signature

Distribute copies to:

1. Payroll
2. Personnel File
3. Employee

Department/Division (attach to employee timesheet)

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