Student Membership Reimbursement Form

Reimbursement request must be within 60 days of the date on receipt.

DATE REQUESTED:	AHIMA MEMBERSHIP #:	
ITEM DESCRIPTION	**AMOUNT**	
Student Membership Reimbursement	**$ 49.00**	

MAKE CHECK PAYABLE TO: **(must be the member/no checks will be made out to 3rd party)**

_____

Address:

_____

_____

_____

Please Print Clearly

REQUESTOR'S SIGNATURE _____

Name of College:

**** Attach a copy of your AHIMA receipt (DO NOT ATTACH Credit Card Info)**
**** Print and attach a copy of your membership card from the AHIMA website**

COMPLETE ABOVE PORTIONS ONLY AND MAIL TO TREASURER:

Treasurer, NJHIMA
C/O New Jersey Hospital Association
760 Alexander Road
PO Box 1
Princeton, NJ 08543

TREASURER _____ **DATE**_____

CHECK NO. _____ **DATE PAID** _____/_____/_____