T.E.A.C.H. Early Childhood® WISCONSIN

Family Child Care Provider/Family Child Care Provider Employee Release Time Reimbursement Claim- FORM C

Family Child Care Provider Name:_______________________________________

Employee Name (if applicable):____

Address:_______________________________________

City, State, Zip:__________________________________

Term Covered by This Claim (Check ONE): O FALL O SPRING O SUMMER 20 ____

Release Time Claimed (Hrs):___________________

Rate of Reimbursement:____$10.00___________

Amount of Reimbursement: __________________

T.E.A.C.H. Counselor:

____

____

(Recipient/Owner of Family Child Care Signature)

____

(Employee of Family Child Care Signature-if applicable)

____

(Date)

Original Copy must be returned to WECA- no faxes or copies accepted

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