Reclamation Manual

Directives and Standards

U.S. Department of the Interior
Bureau of Reclamation
Human Resource Policy

Wellness Program Fitness Reimbursement Request
Appendix C

Fitness Reimbursement Request

This form is required for reimbursement under the Reclamation Wellness/Fitness Program.

Employee's Name:_____ Org/Office/Unit:_____

- Dates or Periods of Purchases/Payments within Fiscal Year: _____
  (October 1 of Prior Year through September 30 of Current Fiscal Year)
- Name of Fitness Center, Fitness or other Class, Wellness Program, or Item(s) for reimbursement, per approved Wellness Agreement:
- Total Cost of Eligible Expenses within Fiscal Year (must match submitted receipts): _____
- Wellness Reimbursement Amount Claimed: $_____ (_____% of total expenses paid, up to a $_____ per local regional wellness plan.) *This is the amount indicated on the Report of Taxable Fringe Benefit form.*
- Reimbursement Funding Information from Employee's Office
  - Fund & WBS: _____
  - Fiscal Tax Year Period (Oct 1 – Sep 30): _____

EMPLOYEE CERTIFICATION

- I understand that the wellness reimbursement is at supervisory discretion and based on my office's funding/budget.
- I attest that I am using the purchased Fitness/Wellness activity/program on a regular and recurring basis.
- I have participated in my purchased wellness activity during my paid membership period and did not cancel/request a refund of my expenses; or, I have only submitted reimbursement for the applicable period that I used the activity prior to cancelling/refund.
- I have included legible copies of my receipts or bank/credit statements with facility or product name and charge clearly stated.
- I have included my prepared IBC Report of Taxable Fringe Benefits form.
- I have included my current Wellness Agreement (Appendix A).

Employee (Type or print name)	Signature	Date

I have reviewed the reimbursement request and acknowledge it is in accordance with an approved Wellness Agreement, Reclamation Wellness Program D&S (HRM 04-12), and the local wellness plan.

Supervisor (Type or print name)	Signature	Date

Regional Wellness Coordinator (Type or print name)	Signature	Date