

**A copy of your RENEWED license is required for processing. Reimbursement will be processed with the next available payroll.**

Please complete the following information regarding your reimbursement:

|  |       |            |      |
|--|-------|------------|------|
| Name (Please Print)  |       |            |      |
| Address (where check will be mailed to)                                      |       |            |      |
| City   | State | WA         | ZIP  |
| Amount Paid  | \$    |            |      |
| Dues or License Type   |       |            |      |
| Department/Division  |       |            |      |
| Requestor's Signature  |       |            |      |
| Requestor's Phone #  | ( )   |            | ext. |
| Department Approval (Administrator or other authorized department personnel) |       |            | Date |
| Signature  | Title | Print Name |      |

Return the following documents:

- 1) Reimbursement Request Form
- 2) Copy of RENEWED License
- 3) Proof of payment (check issued or online receipt)

Mail to: UW Physicians - Finance                      Fax to: 206.520.5168  
 Campus Box 359110  
 or  
 PO Box 50095    Contact: 206.520.5778  
 Seattle WA 98145-5095

Or Email: UWP Payroll at [UWP-Phys-Payroll@uwp.washington.edu](mailto:UWP-Phys-Payroll@uwp.washington.edu)

| UWP USE ONLY  |                 |
|---|-----------------|
| <input type="checkbox"/> Qualifies for reimbursement.         | <i>Exp Date</i> |
| <input type="checkbox"/> New <input type="checkbox"/> Renewal |                 |
| Comments:   |                 |

| PAYROLL USE ONLY |  |
|------------------|--|
| PHYS #           |  |
| DEDCODE          |  |
| FTE              |  |
| TITLE            |  |