



Seasonal Flu Vaccine Reimbursement Form

Please PRINT legibly so we can expedite your request

Program (circle one): Campus Pharmacy Distance Pharmacy Physical Therapy
 Campus Occupational Therapy Distance Occupational Therapy

Graduation Year: _____

First Name: _____ Last Name: _____

Net ID: _____

What city and state did you receive the vaccine in? _____

What is the name of the pharmacy/clinic where you received the vaccine?

Amount of Reimbursement: _____

What address would you like us to send your reimbursement?

Name: _____

Address: _____

City and State: _____

Zip Code: _____

Phone Number: _____

Send this form and your original receipt to:

Season Flu Vaccine Reimbursement
School of Pharmacy and Health Professions
Office of Academic and Student Affairs
c/o Laurie Massa
Criss III, room 154
2500 California Plaza
Omaha, NE 68178

Keep a copy of this form and your receipt for your records.

Office use only

_____ Date Received _____ Database _____ Dean's Office _____ Reimbursement Sent _____ Student Health