Post-Traumatic Stress Disorder Voucher

Applicant Name: ______________________________ Firefighter #: ____________________________

Phone #: _____________________________________ Email: _________________________________

Address: ____

Fire Department: ____

TYPE OF SERVICE

Please select one of the following:

☐ Therapy ☐ Medicine ☐ In Patient ☐ Out Patient ☐ Other–Explain

Other Explanation: ____

REIMBURSEMENT REQUEST

Licensed Medical Professional: _____________________________ Date of Visit:__________________________

Licensed Medical Professional Phone #: ____

Licensed Medical Professional Address: ____

Requested Reimbursement Amount: $____

List itemized receipts and the requested reimbursement amount below

Attach Receipt(s)

SERVICE				
Date	**Location**	**Treatment**	**Itemized Amount**	**Reimbursement Amount Requested**
Total Reimbursement Approved:				

Applicant Signature: ____Date:________________________