Line-of-Duty Stress Injury Program 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 Requested:				

Applicant Signature: _____Date:_____