

FAMILY CARE EXPENSE RECEIPT - PLEASE PRINT

TO: Union of Veterans' Affairs Employees

This will certify that I am providing care to:

Name of Member _____

For _____ person(s) for a period of _____ days, at a charge of \$ _____

per person, per day. The total amount to be paid is \$

Name and address of care provider:

Signature of care provider: