WICHITA CENTER FOR GRADUATE MEDICAL EDUCATION

EDUCATION ALLOWANCE REIMBURSEMENT

DATE: _____

NAME: _____ PROGRAM: _____

Please complete the following:

ITEMS PURCHASED	AMOUNT
TOTAL	$0.00

Please attach a copy of your receipt(s)

_____ _____

Resident Signature WCGME Signature

Return form to: WCGME
1010 N. Kansas
Wichita, KS 67214