COVID-19 Testing Claim Form

(Please print clearly)

Name ______________________________ Date ______________

Street ______________________________ Last for of SS# ______________

City, State Zip ______________________________

10.00/hr.

COVID-19 Testing Claim Form

Date	Total
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$

.

Total	$

Signature and Title of Claimant ______________________________ Date ______________

Signature of Supervisor ______________________________ Date ______________

Budget Code ______________________________

Please return to Payroll after signatures' are complete. Please follow timesheet pay schedule.

Updated Oct 2021

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