

REFEREE FEES REIMBURSEMENT FORM
LOCUST VALLEY BAYVILLE SOCCER CLUB
P.O. BOX 115
Locust Valley, NY 11560



Parent coordinator name: _____

Address: _____

Phone Number: _____ E-mail: _____

Date / Opponent	Age	Game Location	Amount

Total: \$

Please list any amount of this sum that you wish to donate to LVBSC* \$ _____

Amount of reimbursement sought \$ _____

I certify that I provided the funds for which I seek reimbursement

Signature

***LVBSC is a 501(c)(3) entity that can accept tax-deductible charitable contributions**

THIS FORM MUST BE SUBMITTED TO THE ADDRESS ABOVE BY DECEMBER 31 FOLLOWING THE FALL SEASON, AND BY JUNE 30 FOLLOWING THE SPRING SEASON. REIMBURSEMENT WILL NOT BE PROVIDED IF THE FORM IS RECEIVED THEREAFTER. ALL REIMBURSEMENT WILL BE PROVIDED BY CHECK.