



# Grant Reimbursement Request Form

Please fill out form completely and attach receipts.

DEPARTMENT INFORMATION	
Date of Request	
Department Name	
Department Address	
Department City/State/Zip	
Contact Name	
Phone	
Email	

INVOICE SUMMARY			
Recruit Name	Hire Date	Description of Purchase (circle one)	Amount
		PPE HEALTH SCREEN	
		PPE HEALTH SCREEN	
		PPE HEALTH SCREEN	
		PPE HEALTH SCREEN	
		PPE HEALTH SCREEN	
<b>Total Amount Requested</b>			

RECEIPTS MUST BE ATTACHED IN ORDER TO BE CONSIDERED FOR REIMBURSEMENT

**Reimbursable PPE Items:** 1 SCBA Mask/Face Piece, 1 pair of pants, 1 coat, 1 helmet, 2 hoods, 1 pair of boots, 2 pairs of gloves, 1 pair of suspenders, 1 pair of goggles.

**In order to be reimbursed for PPE, you must provide proof that the firefighter has passed an NFPA 1582 compliant physical and is "fit for duty".**

MSFDA PROCESSING				
Check Number		Amount	\$	Date Approved
Date Received		Other Notes		
Approved By				

Send completed form and supporting documents to:  
 Mail: MSFDA – 28711 Holly Drive NW, Isanti, MN 55040  
 Email: [deedee@msfda.org](mailto:deedee@msfda.org)  
 Questions? 763-221-9329 or [deedee@msfda.org](mailto:deedee@msfda.org)

