

Clinic Reimbursement Request

**THE NIOA will reimburse officials for ½ of clinic cost up to \$50.
Receipt and copy of registration from clinic must accompany this form.**

Date of Clinic: _____ Location: _____

Name of Clinic: _____ Requested
By: _____

Address: _____

**Please send request to:
Tim Esbeck - NIOA Treasurer
MBT
PO Box 32
Clear Lake, IA 50428**