Eye Care for Kids Foundation Monthly Statement

Month: _____ Year: _____

Date	Student Name	Approval Code	Exam Reimbursement Until 2/14/10 - $29 After 2/14/10 - $0	Frame & Lens Reimbursement $50	High power polycarb $20 (Include RX)	Parent Contribution (If applicable)	Total Reimbursement	$ Amount of Services Donated by Dr*
		Totals:						

Please submit the monthly statement via fax to: 713-728-9304

Indicate if the vouchers are following the fax, or being mailed separately.

___ Vouchers are being faxed

___ Vouchers are being mailed (you must still fax in the statement)

Mail Vouchers to:

Eye Care for Kids Foundation
9660 Hillcroft, Suite 325
Houston, Texas 77096

***Criteria for Poly is Sphere = +/-5, Cylinder = +/- 3 or over in either eye. Prescription required for reimbursement.**

**** Your Retail Price (_____) minus Our Reimbursement (_____) minus Parent Contribution (_____) Equals Amount Donated by Doctor**

Doctor's Signature:_____
Practices Name:_____
Address: _____
City, State, Zip: _____
Telephone Number: _____
Fax Number: _____