WorkLife Office
Building 310, Main Quad
Stanford University

Adoption Assistance Expense Reimbursement Claim

Date:_____

Employee Information:

Stanford University Employee's Name: Last	First	M.I.
SU ID Number:	Social Security Number: - -	

Contact Information:

Home Address: Street	City	State	Zip
Work Address: Street/Building/Room #			Mail Code
Email:	Department:		Daytime phone:
Spouse/Partner's Name:	Spouse/Partner's Employer:		

Child's Information:

Child's Name:	Date of Birth:	Social Security Number: (if known) - -
Date of Adoption:	Is the child in your home?	

Expense Information:

Date:	Paid to:	Services Rendered:	$ Amount

(Attach separate sheet of paper for additional expenses.)

By signing below, I certify that I have attached all applicable documentation for reimbursement under Stanford University's Adoption Assistance Program. I understand I must notify the WorkLife office of any change regarding the adoption. I certify under penalty of perjury that all statements and documentation relating to this claim are complete and true. I understand that incomplete or inaccurate information may adversely affect my eligibility under this program up to and including repayment to Stanford University of any funds awarded, and/or may result in adverse employment consequences for myself.

Employee signature: _____ Date: _____