Parent:

CLACKAMAS COMMUNITY COLLEGE
Associated Student Government Childcare Grant
Childcare Provider Invoice

Provider _____ Phone _____

Address _____

City _____ State _____ Zip _____

Provider Number or Social Security Number _____

Name of Parent _____

Parent's Social Security Number _____ Amount of Award _____

Name of Child _____

Please list the dates child care was provided and number of hours. (Example: 01/03/12 - 8 hours)

Date	Hours (Example: 8:00am – 2:00pm = 6 hours)	Daily Total

Reimbursement Request: _____ **X** _____ **=** **$** _____

Hours/days **Hourly/daily Rate** **AMOUNT DUE**

Less payment (if any) to provider **$** _____

Net amt to be paid from CCC Childcare Grant Fund **$** _____

I certify that the above information is true, accurate, and complete.

_____ _____

Provider's Signature Date

When the amount due reaches $ _____ (amount of award), please mail this form to:

Clackamas Community College Associated Student Government 19600 S. Molalla Ave.
Oregon City, OR 97045 ATTN: Grants Officer Phone 503-594-3934 Fax 503-650-7345