Successful Learners Strengthening Our Community

Mount Vernon Schools

REQUEST FOR REFUND from ASB Fund

Date: _____

Staff Name: _____ _____
Site

Student Name: _____

Reason for Refund: _____

Amount $ _____ Receipt # _____ Receipt Date _____
(Copy of Receipt Required)

Make check payable to: _____
Please print parent/guardian name

Mail to: _____

_____

Verified by: _____
ASB Secretary

_____
Primary Advisor/Principal Signature

_____
Student Signature

IF REFUND UNDER $25, BRING SIGNED FORM WITH RECEIPT TO DISTRICT OFFICE FOR IMMEDIATE REFUND IF NO OTHER FEES/FINES/NSF'S OWED BY FAMILY. IF OVER $25, THERE IS A 14-DAY PROCESSING TIME.

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For Business Office Use Only

Fees & Fines _____ NSF _____

Siblings _____ Fees & Fines _____ NSF _____

Siblings _____ Fees & Fines _____ NSF _____

Account Code _____ _____
GL Acct Code