THE WINNIPEG TEACHERS' ASSOCIATION (FAX 837-9698)

DEPENDENT CARE STATEMENT OF EXPENSES

Name : _____ *(Please print)*

School : _____

Date of Council meeting: _____

*No. of hours required for dependent care :*_____

_____
Signature

Please note that according to Council Policy C11 XII . Council meetings shall not exceed 3.5 hours.

FOR OFFICE USE ONLY

No. of hours for dependent care = _____ x MTS rate _____ = $ _____

Budget Line = Dependent Care

Date : _____ Cheque: _____