Central Vancouver SC Referee Reimbursement

All requests for reimbursement must be submitted within 60 days of the match.

Referee Name: _____ **Phone Number:** _____

Address: _____ **Zip:** _____

Game Date	Location	Time	Age/Division	Position (CR or AR)	Home Team	Away Team	Amount
Clinics, USSF Fees - Attach your receipts							

	CR	AR
Mini-Mod U-6/7/8	10.00	N/A
U-9/10	12.00	N/A
U-11	15.00	10.00
U-12	17.00	10.00
U-13/14	20.00	10.00
U-15/16	25.00	12.50
U-17/18/19	25.00	15.00
District 5 League		
U-11/12	25.00	15.00
U-13/14/15/16	30.00	15.00
U-17/18/19	35.00	17.50

Please mail the form to: **CVSC Treasurer**
PO Box 5919
Vancouver, WA 98668

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(referee signature)