AIR FORCE HEALTH PROFESSIONS SCHOLARSHIP PROGRAM (AFHPSP)
REQUIRED REIMBURSEMENT(S) ACCOUNTING LIST

NAME (Please print or type last name, first name, middle initial)	SSN	PHONE (Include Area Code)

CURRENT ADDRESS (Include Street, State, and Zip Code)	SCHOOL	DEGREE PROGRAM
	E-MAIL ADDRESS	AFHPSP ELIGIBILITY DATE / GRADUATION DATE

	REQUIRED ITEMS (Insurance, book title, equip, boards)	COURSE NUMBER AND DESCRIPTION	QTY	UNIT COST	TOTAL COST	FOR AFIT USE ONLY			
						ALLOWED	CODE	REASON	RESUBMITTAL
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

AFIT FORM 31, 20010315 (EF-V1)   PREVIOUS EDITIONS ARE OBSOLETE

NAME *(Please print or type last name, first name, middle initial)*

	REQUIRED ITEMS *(Insurance, book title, equip, boards)*	COURSE NUMBER AND DESCRIPTION	QTY	UNIT COST	TOTAL COST	FOR AFIT USE ONLY			
						ALLOWED	CODE	REASON	RESUBMITTAL
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									
37									
38									
39									
40									
41									
				SUBTOTAL				SUBTOTAL	
				+ TAX				+ TAX	
				TOTAL				TOTAL	

I certify that this claim for reimbursement is for items that are required and actually used for academic/clinical attendance by myself and all other students at this institution pursuing a like degree during the current academic period (Starting _____ Ending _____). I also understand that tuition and related fees, textbooks, supplies, and equipment required for postgraduate education programs beyond AFHPSP are nonreimbursable. I certify all required documents to support this reimbursement are attached.

SIGNATURE OF STUDENT	DATE

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