Longwood Medical Area Child Care Center, Inc.

TUITION RECEIPT REQUEST FORM

Parent's Name: ____

Parent's Name: ____

Home Address: ____

City:____________________________ State: ______ Zip Code: ________

Email address 1: ____

Email address 2: ____

Customer ID or Child's Name: ____________________________________

Customer ID or Child's Name: ____________________________________

Customer ID or Child's Name: ____________________________________

Customer ID or Child's Name: ____________________________________

Please indicate the month(s) or year for your receipt:

Month(s): _____________________ to ___________________________

Year: __________________________

Please select how you want to receive it.

Mail to Home address ☐ **Send as a pdf document to Email address** ☐

Please allow 10 days for LMACCC to process your request. If you have any questions or concerns, please email jkaufman@masco.harvard.edu. Completed form can be dropped off in the drop box at LMACCC office, emailed to jkaufman@masco.harvard.edu, or faxed to 617-582-6852.

Signature: ____

Signature: ____

Date: ______________________