

Refund Request

ACT-001

Make check payable to:

Payee _____

Permit Number _____

Mailing Address _____

City/Town _____ State/Zip _____

Signature By signing you are stating that these monies are due to you. _____

Reason for refund must be stated or refund will be denied.

COPY OF RECEIPT MUST BE ATTACHED

----- DO NOT WRITE BELOW THIS LINE - To Be Completed by PRMD Staff -----

PRMD Staff Name:	_____	Date Request Received: _____
Manager's Signature:	_____	<input type="checkbox"/> Partial Refund \$ _____
Date signed:	_____	<input type="checkbox"/> Full Refund
		<input type="checkbox"/> Recommend Disapproval of Refund (If not approved, state reason in Comments)
Expenses Incurred:	Number of Hours Spent Working on File/Staff Name: ____ / _____	
	Other Expenses (Description & Dollar Amount): _____	
Fees Eligible for Refund:	_____	
Comments:	_____ _____ _____ _____	

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Refund Type:	_____
Payment Amount:	Fees Paid: \$ _____
	Non-refundable Fees: \$ _____
(Less):	Other Expenses (-10% if Withdrawn): \$ _____
	Staff Time: \$ _____
	Total Refund: \$ _____