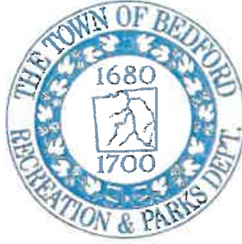

REFUND REQUEST

Name:	
Full Address:	
Home Phone:	**Cell Phone:**
Email:	
Participant Name(s):	
Program(s) Name Refund is Requested:	
Reason for Refund:	

Signature: ______________________________ Date: ____________________

***Note: Refunds for medical reasons may require a doctor's note.**

Office Use Only

Amount Paid: $__________ Processing Fee: $__________ Date: ______________

(minimum processing fee is $10 for programs; $25 for camps)

Refund Amount Approved: $__________ Approved by: ______________________

Superintendent of Recreation & Parks

Notes: ____

____

Town of Bedford Recreation & Parks Department ~ 425 Cherry Street, Bedford Hills, NY 10507
Tel. # 914-666-7004 Fax # 914-666-3863 Recreation@BedfordNY.gov

4/10/17