School Nutrition Services

Rowan-Salisbury SCHOOL SYSTEM
Extraordinary Education Every Day
Be an original.

Request for Refund of Account Balance

School: _____ **Request Date:** _____

Name on Account: _____

Student ID #: _____

Amount of Refund: _____

I am requesting a refund from the account listed above. I realize that a check will be mailed from the School Nutrition Services Office and that it may take two (2) to three (3) weeks for the check to be processed and mailed.

Signature: _____

Relationship to Account Holder: _____

Please provide the name and address to which a refund check is to be mailed:

_____

Please Print **Name**

_____

Address

_____

City , State, Zip

_____

Phone # where you may be reached in case clarification needs to be made.

*Please return this form to the cafeteria manager at your child's school or mail to:

Rowan-Salisbury Schools
Attn: School Nutrition
PO Box 2349
Salisbury, NC 28145-2349

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