



# Request for Reimbursement of Substitute Teacher

All fields with \* must be completed

## SECTION 1: To be completed by the Person Submitting Form *(please print)*

* Name of School District:		
* Name of School:		
* Name of Administrator:		
* Signature of Administrator:		
* Name of CDE Function:		
* Location of CDE Function:		
* Date of CDE Function:		
* Name of Teacher(s) Requiring Substitute:		
* Date(s) Substitute is Required:		
* Phone of Teacher Requiring Substitute:		
* Daily Substitute Rate: \$	* Number of Days:	* Total Requested: \$
* Submit check to:	<input type="checkbox"/> School District <input type="checkbox"/> School <ul style="list-style-type: none"><li>• Please provide address of school <i>if</i> you would like the check mailed there</li></ul>	

## SECTION 2: To be completed by the Health & Wellness Unit

Fund Number: 919B-1406	Signature:	Date:
Please return warrant to Susanna Spear, x6719		

Revised: March 18, 2011