




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 Number of School:		
* Daily Substitute Rate: \$	* Number of Days:	* Total Requested: \$
* All checks will be submitted to District Offices. Please provide the name and address for your school district in the box to the right. 		* District:

SECTION 2: To be completed by the Colorado Department of Health & Wellness Unit:

Fund Number: 914C-1406	Signature:	Date:
Please return warrant to: Danny Mitchell , phone: 303.866.6719 email: mitchell_d@cde.state.co.us		




COLORADO
Department of Education

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Instructions on Filling out Form:

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Comment [MD1]: Name and signature of Administrator giving you permission to attend the training.

Comment [MD2]: Daily rate is what CDE is reimbursing substitute.

Comment [MD3]: The rate total should include the salary and benefits for the teacher. Get in touch with your district accounting department for the totals.

Comment [MD4]: If you don't know the address for your district get in contact with your administrator.

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