

**Request for Reimbursement of Substitute**

***All fields with***  ***must be completed***

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

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|  Name of School District: |
|  Name of School: |
|  Name of Administrator: |
|  Signature of Administrator: |
|  |
|  Name of CDE Function: Take Action! Review, Update and Strengthen your Local Wellness Policy  |
|  Location of CDE Function: |
|  Date of CDE Function**:** |
|  |
|  Name of Employee(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.**Once signed, email to:** Stacey Macklin at macklin\_s@cde.state.co.us **OR mail to:** CDE Office of School Nutrition Attention: Stacey Macklin 1580 Logan St., Suite 760 Denver, CO 80203 | District:

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**CDE OFFICIAL USE ONLY**

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| Fund Number:  | Signature: | Date: |

**SECTION 2: To be completed by the Colorado Department of Education**