

**Request for Reimbursement of Substitute**

***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: 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](mailto: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:   |  | | --- | |  | |  | |  | |  | |  | |  | |  | | |

**CDE OFFICIAL USE ONLY**

|  |  |  |
| --- | --- | --- |
| Fund Number: | Signature: | Date: |

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