

LOCKPORT AREA SPECIAL EDUCATION COOPERATIVE

1343 E. 7th St.-Lockport, IL. 60441

815-838-8080

Fax 815-838-8086

**REQUEST FOR REIMBURSEMENT FOR
INSERVICE OR PROFESSIONAL DAY**

Name: _____ Date Submitted: _____

Work Phone: _____ Home Phone: _____

Position: _____ Site: _____

Name of Inservice: _____ Date of Inservice: _____

Instructions for completing this form:

1. Complete one (1) Reimbursement Request Form for each inservice activity.
2. Submit this form to the Executive Director at the above address.
3. Documentation of expenditures must be attached to the Request for Reimbursement Form. Acceptable types of documentation are copies of cancelled checks, receipts, or tickets if the price is on the ticket.
4. For mileage only: The total number of miles is required along with any tolls. Tolls over \$0.50 require receipts.
5. Requests for reimbursement should be submitted by the 25th of the month to be paid the following month.

Changes in inservice project description:

Specify any changes in the inservice activity from the proposal, as submitted, on the Request for Inservice or Professional Leave Day Form.

Expenses:

Itemize the expenses incurred in this inservice activity for which reimbursement was pre-approved and is requested. Attach the required documentation for each expense item to this form.

Lodging: _____ Registration: _____ Mileage: _____ Meals: _____

Other: _____ **Total: \$** _____

Signature of Employee

Please process this reimbursement request for payment.

Executive Director

Date

Return Completed Form to Executive Director for approval

For Office Use Only: Amount: _____ Date Paid: _____ Check # _____

Original: Business Office cc: Personnel Office

Revised 8/00