# License/ASHA Certification Reimbursement

Employee Name: _____ (Last / First / M.I.)

Employee ID # _____

Position/ Subject: _____

Location/School: _____

| License/ASHA Certification | Fees | Validity dates |
|---|---|---|
| | $ | / / to / / |
| | $ | / / to / / |
| | $ | / / to / / |

* Complete the fillable parts of this form.
* Submit as a complete packet the following three (3) items:
  * Request for License/ASHA Reimbursement Form
  * Copy of License
  * Copy of billing invoice

** Do not send items separately. Incomplete packets will delay reimbursement.

** Retain a copy for your records.**

**Return completed forms to Sharon Adams in Human Resources**

Per the CCEA negotiated agreement the following licenses are eligible for reimbursement:

_____ Speech Language Pathologist
_____ Teacher of Visually Impaired
_____ Occupational Therapist Assistant
_____ Social Worker
_____ Behavior Specialist
_____ Physical Therapist
_____ Occupational Therapist
_____ Physical Therapist Assistant
_____ Registered Nurse

| Office Use Only | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
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*Total:* $ _____ *DHR Approval:* _____ *Date:* _____ *Accts Payable:* _____