Continuous Education Unit Reimbursement

Employee Name: _____ Employee ID # _____
Last First M.I.

Position/ Subject: _____ Location/School: _____

Organization	Continuous Education Activity	# of CEU's	Total Cost	Date of Activity (mm/dd/yyyy)
			$	/ / to / /
			$	/ / to / /
			$	/ / to / /

Reimbursement maximum is equivelent to nine (9) credits per fiscal year from July 1 to June 30.

* Complete the fillable parts of the form.
* Upon completion of the Continuous Education Activity submit as a complete packet the following three (3) items:
  * Request for CEU Reimbursement Form
  * Copy of CEU's
  * 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

_____ Speech Language Pathologist
_____ Teacher of Visually Impaired
_____ Occupational Therapist Assistant
_____ Physical Therapist
_____ Occupational Therapist
_____ Physical Therapist Assistant

Employee Signature: _____ Date _____

OFFICE USE ONLY										
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Total: $ _____ *DHR Approval:* _____ *Date:* _____ *Accts Payable:* _____

7/2019