License/ASHA Certification Reimbursement

Employee Name: ______________________________ Employee ID #: ______________________

Position/Subject: ______________________________ Location/School: ______________________

License/ASHA Certification	Fees	Verify Dates (mm/dd/yyyy)
	$	to
	$	to
	$	to

*Complete the fillable parts of the 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.

Please return completed forms to tuitionreimbursement@carrollk12.org or via pony to:
Human Resources Office, Attention: Tuition Reimbursement

_____ Speech-Language Pathologist
_____ Teacher of Visually Impaired
_____ Occupational Therapist Assistant
_____ School Social Worker
_____ Behavior Specialist
_____ Mental Health Therapist
_____ Physical Therapist
_____ Occupational Therapist
_____ Physical Therapist Assistant
_____ Registered Nurse
_____ Autism Behavior Consultant
_____ Alt. Program Intervention Specialist

Employee Signature: ______________________________ Date: ____________________

OFFICE USE ONLY:

1	1	13				000	162	4	99

Total: $ ____________ *DHR Approval:* ________ *Date:* ________ *Accts. Payable:* ________

12/2022