OSSTF District 15 - Trillium Lakelands
Educational Services Fund Application
2019-2020

PLEASE SEE REVERSE FOR FUND PROCEDURE / GUIDELINES

Name: _____ **School:** _____

Personal Email Address: _____

For use in the event that elements of your application require clarification or additional documentation is requested.

Program Name: _____

Description: _____

_____

Date of Program: _____ **Dates of Absence from School:** _____

Location / Address Where Program Occurred: _____

The deadline for applications to be received by the District Office will be May 15, 2020.
In order for a course, workshop or other activity to be eligible it must have been paid for by April 30, 2020.

Please talk to the Education Services Representative at your worksite if you are unsure as to the eligibility of your claim.

PLEASE REMEMBER:

- ☐ To attach a brochure / agenda / overview of the conference or workshop, regardless of whether or not you are claiming registration fees;
- ☐ To attach all supporting documentation and receipts. Documentation for courses must include the your name, the amount paid, the name of the course, and date/time period of the course;
- ☐ To indicate the names of any passengers that travelled in your vehicle;
- ☐ To indicate where costs have been covered by other sources (eg. if your principal has covered your registration costs).

THANK YOU!!

CLAIMED AMOUNTS	TOTAL COST (incl. HST)	HST Paid
Registration Fees:		
Meals:		
Maximum: $30 / half day, $60 / full day		
Hotel:		
Maximum $200 per night		
Parking:		
Maximum $20 per day		
Mileage: Distance: _____ KM		
Rates: $0.42/km, $0.55/km – 1 passenger, $0.70 – 2 or more passengers Total Cost: _____		
Maximum $200; $400 for multiple trips where no hotel is claimed		*Passengers' Names*
LESS		**Source:**
Funding From Other Sources:		
TOTAL CLAIM AMOUNTS:		

Member Signature: _____ **Date:** _____

Branch Ed. Services Rep: _____ **Date:** _____

FOR OFFICE USE ONLY:

Date Claim Approved: _____ **Signature Ed Services Chair:** _____

Total Amount Approved: _____ **First Amount Reimbursed:** _____