



**OSSTF District 15 - Trillium Lakelands
Educational Services Fund Application
2017-2018**

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 16, 2018.

In order for a course, workshop or other activity to be eligible it must have been paid for by April 30, 2018.

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:	_____	_____
	<i>Maximum \$170 per night</i>	
Parking:	_____	_____
	<i>Maximum \$20 per day</i>	
Mileage:	Distance: _____ KM	_____
Rates: \$0.42/km, \$0.55/km - 1 passenger, \$0.70 - 2 or more passengers	Total Cost: _____	
		<i>Passengers' Names</i>
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: _____