INVOICE for SUBSTITUTES
(FAU and PAEC)

Please reimburse _____ school district for the cost of a substitute teacher, as specified below.

Teacher for whom substitute was obtained:

Name:
School:
Mailing Address:

Telephone Number:
Social Security Number:

Substitute:

Name:
School:
Mailing Address:

Telephone Number:
Social Security Number:

Date and hours substitute worked: DAY: HOURS:

Cost to be reimbursed:

Reason for use of substitute:

School District FEID Number:

Address to which check should be mailed:

_____
Authorized Signature

After you have attended the workshop, please complete this form and fax it to Florida's Coordinated School Health Program at (850) 245-1156 or SunCom 205-1156.

FOR PROJECT USE ONLY

Substitute authorized by Project? ☐ Yes ☐ No

Project Expenditure should be charged to: