INVOICE for SUBSTITUTES
(FAU and PAEC)

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

Teacher for who substitute was obtained:

Name:
School:
Mailing Address:

Telephone Number:
Social Security Number:

Substitute:
Name
School:
Mailing Address:

Telephone Number:
Social Security Number:

Date(s) and hours substitute worked:

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) 245-5116.

FOR PROJECT USE ONLY

Substitute authorized by Project? ____Yes ____No

Project Expenditure should be charged to: _____