ROWAN-SALISBURY SCHOOLS
Request for Reimbursement
For Transportation and Bus Drivers

Check appropriate
Reimbursement request(s):

Original CDL ☐
Renewal CDL ☐
Medical Only ☐

Name _____ **Last 4 of SS#** _____

Mailing Address _____
Street **City** **State** **Zip**

School: _____ **Job Title:** _____

Activity Bus only? **Yes / No (circle one)** **New hire?** **Yes / No (circle one) if yes: hire date** _____**cdl issue date**_____

***PLEASE NOTE** If you are employed less than 90 days from the issue date of your CDL, this reimbursement will deducted from Your final paycheck.* **My signature indicates that I have read and understand these guidelines for reimbursement.**

Employee Signature: _____**Date:** _____

In order to be reimbursed you must attach photocopies of the following and return to the Transportation Dept.

- Receipt from NCDMV showing cost of license
- CDL
- Receipt from ProMed for DOT Medical Card/Physical / DOT Drug Test
- DOT Medical Card

****Please be advised: If you choose to go to a Medical Provider other than ProMed, you may not be reimbursed your full cost. We only reimburse at ProMed's cost****

Requests without these copies will be returned to the employee. In order to expedite your request, please turn in all copies of receipts at the same time with this completed form.

******Section below to be completed by the Transportation Department******

License Number _____ **DOT Medical Card/Physical $**_____

Cost of License $_____ **DOT Drug Test $**_____

Budget code:
2.6550.706.311

COST OF MEDICAL TESTS: $ _____
COST OF LICENSE: $ _____
(Less Cost of Personal License) $ _____

TOTAL REIMBURSEMENT: $ _____

Director of Transportation signature _____ Date _____

THIS INSTRUMENT HAS BEEN PREAUDITED IN THE MANNER REQUIRED BY THE SCHOOL BUDGET & FISCAL CONTROL ACT.

Chief Finance Officer signature _____ Date _____

Form Revised 7/21