

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

Check appropriate  
 Reimbursement request(s):

Original CDL  
 Renewal CDL  
 Medical Only

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

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 \_\_\_\_\_

Have you renewed with DMV/SBTS \_\_\_\_\_? Renewal 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 the service offered at Transportation, or Promed, you may not be reimbursed your full 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:  
 2.6550.706.353

**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 \_\_\_\_\_