Licensed Family Child Care Provider Training Reimbursement

Date: _____

Provider Name: _____

Program License #: _____

Common ID #: Last five digits of SSN or TIN# - Full birth date (mm/dd/yyyy)

_____

Payment Street Address:

_____

City, State, Zip: _____

Phone: _____

NOTE: Invoices submitted with missing data and/or signatures will have payment held until completed form is received. A Western Oregon University (WOU) Substitute W-9 is required for payment. A copy of the completed training certificate and original receipt must accompany this invoice. A maximum of $55.00 is authorized for reimbursement of Infant First Aid/CPR and/or Recognizing and Reporting Child Abuse and Neglect (RRCAN).

DATE OF TRAINING	TRAINING	AMOUNT (Max $55.00)
	INFANT FIRST AID/CPR	
	RRCAN	

Participant Signature: _____ Date: _____

Did I attach the following:

- Training Certificate
- Original Receipt
- WOU Substitute W-9

Send completed forms to:
Western Oregon University
TRI/Central Coordination of CCR&R
345 Monmouth Ave N.
Monmouth, Oregon 97361
Phone: 800.342.6712

Business Office Use Only:
Index: TRI 253
Account Code: 24998