SFUSD SAN FRANCISCO PUBLIC SCHOOLS

HUMAN RESOURCES
555 Franklin Street
San Francisco, CA 94102-5299
Tel (415) 241-6101 Fax (415) 241-6147

REIMBURSEMENT FORM FOR TUBERCULOSIS TEST CO-PAY

EMPLOYEE NAME_____ **ID NUMBER:** _____
PAY CYCLE (Circle One) Monthly BiWeekly **JOB TITLE:**_____
PLEASE INCLUDE:

Receipt
Proof of payment [if not paid in cash, eg card statement]

DESCRIPTION	DATE	TEST FACILITY	CO-PAY AMOUNT ONLY
Tuberculosis Test Co-Pay			

I hereby affirm that I received a Tuberculosis test in compliance with California Education Code, Section 49406, and am seeking reimbursement for my co-pay charge from San Francisco Unified Public Schools.

_____ _____
Employee signature *Date*

SECTION TO BE COMPLETED BY HUMAN RESOURCES:

Approved by:

_____ _____
Dept. Head/Supervisor *Date*

Paygroup: _____EE Record Number:_____

SACS Code: _____