

HSD Central Administrator's

Professional Growth Form

As described in **Administrative Salary Schedule 1,** central administrative personnel are eligible for up to $1,800 per person, per contract year for professional development. Requests must be submitted and approved in advance by the immediate supervisor and the Human Resources Office for reimbursement. The contract year begins July 1st and ends June 30thth of each year. Requests must be submitted and paid for prior to August 31st of each year or funds will posted to the next schools year’s allocation.

***For approval and reimbursement, please attach all registrations and/or receipts to this application. If a purchase order has been utilized, please include a copy of the completed purchase order and with the appropriate PO number.***

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| eMPLOYEE INFORMATION |
| Employee Name:       |
| **Address:** |
| **Name of Supervisor** |
| Work Phone Number       | ID Number       |
|  |
|  |
| **Class information** |
| Course /Workshop/ Title /No. |
|       |
| **Location of Course/ Workshop** | Dates of Class |
|       | **to**  |
|  |
| Cost of Class | **Travel Costs**  |
| Tuition |  | **Lodging** |  |
| Registration |  | **Mileage** |  |
| Supplies |  | **Refund Per Mile** |  |
| **Materials** |  | **Other Ex*. (itemize on back)*** |  |
|  |  |  |  |
| **Total** | **$** | **Total** | **$** |
|  **Grand Total:$**  |
| I hereby certify under penalty of perjury that this is a true and correct claim for necessary expenses incurred by me and that no payment has been received by me on account thereof.*Signature of Applicant*: Date:  |
| ***Supervisor’s Signature*:**  | **DATE:** |
| ***Human Resource Signature*:**  | **DATE**: |
|  Budget Number: 0320-(21 or 31)- \_ \_ -5722 (Please enter location code in blanks provided) Amount Approved: $ \_\_\_\_\_\_\_\_\_\_\_\_  |

Please send completed form and all supporting documents to Human Resources. Questions, please call (206) 631-3008.

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| **ITEMIZED EXPENSES WORKSHEET** |
| **Materials/Supplies (Must be Itemized)** | **Actual Amount** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| *Total Amount of Materials:* |  |
| *Total Reimbursable Amount\*:* |  |

***\*Total Reimbursable Amount should match Page 1***

***\*\*\*RECEIPTS REQUIRED\*\*\****

***Reimburse Employee. Mail check to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Pay directly to Vendor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Vendor Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***