**Bakersfield Chapter Test Reimbursement Request**

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| **Name:** |  | **Phone #:** |  |
| **Address:** |  |  |  |
| **City:** |  | **State:** |  | **Zip Code:** |  |
| **Employer:** |  |  |  |  |  |
| **Supervisor Name:** |  |  |  |
| **Supervisor Email:** |  | **Phone #:** |  |
| **ASSP Membership #:** |  |  |  |
| **Test Passed**: | **[ ]  CSP** | **[ ]  ASP** | **[ ]  OHST** | **[ ]  CHST** | **[ ]  STS** | **[ ]  SMS** |
|  | **[ ]  OTHER TEST:** |  | **ORGANIZATION:** |  |

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| **Test Verification** |  |
| **Date Passed:** |  |
| Reimbursement requests should be made within six months of the certification date |  |
| **Test Reimbursement Amount:** | **$** |  | **USD** |
| Include a copy of the payment receipt. Note: only the test fee is subject to reimbursement |  |
| **Certification Verification: Please include a copy of your certification and/or the BCSP letter indicating successful completion of certification** |

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| **Reimbursement \*** |  |
| **[ ]  I am a member of the Bakersfield Chapter of ASSP. The BCSP Certification exam expense that I am requesting reimbursement for has not been reimbursed by an employer or any other source, and I will not try to obtain reimbursement in the future for this certification from any other source.** |
| **Event:** (where will reimbursement be presented) | **Date:** |
| **[ ]  ASSP Monthly Breakfast Meeting** (Hodels – first Wednesday at 7:00 am) |  |
| **[ ]  Other** (agreed upon by EC and recipient) |  |
|  |  |
| **Signature:** |  | **Date:** |  |
|  |  |  |  |

**\*Reimbursement is limited to one per member, per year. Reimbursement is subject to Executive Committee approval.**

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| **ASSP Bakersfield Chapter Committee Use Only** |
| **Motioned by:** |  | **Date:** |  |
| **Executive Committee Decision:** | **[ ]  Approved** **[ ]  Denied** |
| **Reimbursement Check Distribution** | **Date:** |  |
|  | **Event:** |  |
|  | **By:** |  |
|  |  |  |