

**Virginia Alternate Assessment Program
SUBSTITUTE REIMBURSEMENT REQUEST**

*Return by November 1, 2000 to:
Mrs. Kim Shackelford
Department of Education
Office of Special Education and Student Services
P. O. Box 2120
Richmond, Virginia 23212-2120
FAX: (804) 371-8796*

School Division: _____
Contact Person: _____ Position _____
Address: _____
Tel. _____ E-mail _____ FAX _____

The Department of Education will reimburse school divisions for the cost of substitutes only for teachers attending training for the Virginia Alternate Assessment Program who will be submitting collections of evidence in the spring of 2001. School divisions will be reimbursed at the rate of \$50.00 per day per teacher.

The following teachers attended Virginia Alternate Assessment Program training:
(Please list)

Total Reimbursement Requested: _____

OFFICE USE ONLY

REIMBURSEMENT REQUEST RECEIVED:

REIMBURSEMENT FORWARDED:

REIMBURSEMENT APPROVED:

