



EXPENSE CLAIM FOR SUBSTITUTE TEACHER
 NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
 OFFICE OF FISCAL MANAGEMENT
 SFN 58965 (11-2021)

I. School Information

School District		
Mailing Address		
City	State	ZIP Code

II. Meeting Information

Title of meeting attended	Meeting Date
Meeting location	Department of Public Instruction Unit sponsoring meeting

III. Teacher Information (attach additional pages if needed)

Name of teacher needing substitute	Number of days to be reimbursed
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IV. Amount of Request

Total number of Days to be Reimbursed _____ x *Daily Rate of \$* _____ = \$ _____ (daily rate not to exceed \$135 per day)

Certification: I certify that this statement truthfully and accurately describes the services rendered, and that the amount of payment will not be duplicated from any other source.

Signature of Authorized Representative	Date
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For Department Use Only:

Contract	Speed Chart	Year	Class 20130	Dept. ID	Fund	Project	Activity	Account	Category
Unit Approval	Date	Grant Mgr.	Date						

Submit to:
 ND Dept of Public Instruction
 Office of Fiscal Management
 600 E Boulevard Ave, Dept 201
 Bismarck, ND 58505-0440