School Name: _____
BEDS Code: _____

EXPENSE REQUEST AND CERTIFICATION

7/1/2023-6/30/2024

Expense Category:	**Amount:**
Teacher Tuition or Test Expenses	_____

CHIEF ADMINISTRATOR'S CERTIFICATION

I hereby certify that the requested budget amounts are necessary for the implementation of this project and that this agency is in compliance with applicable Federal and State laws and regulations, that these monies will be disbursed as supplemental compensation to teachers and that these monies will not be used to supplant teacher compensation received from other revenue sources. I further certify that when these expenditures become base year expenses, they will be reported separately from other teacher compensation so as not to be reimbursed in subsequent years calculations of tuition rates.

_____ _____

Date **Signature**

_____

Name and Title of Chief Administrative Officer

Phone #:_____**Fax #:**_____**E-Mail Address:**_____

Note: You must complete and return this document with the Chief Administrator's original signature by January 12, 2024 to the attention of Shaakima Smith at the New York State Education Department, STAC & Medicaid Unit, Room 25 EB, 89 Washington Avenue, Albany, NY 12234. Replications will not be accepted.

<table>
<tr><th>STAC & Medicaid Unit APPROVAL:</th><th colspan="3">FOR SED USE ONLY</th></tr>
<tr><td rowspan="3">Approved By:

Name:

Date:</td><td>Fiscal Year:</td><td>Amount Expended:</td><td>Final Payment:</td></tr>
<tr><td colspan="2">Voucher Number:</td><td>First Payment:</td></tr>
<tr><td>Log</td><td>Approved</td><td>MIR</td></tr>
</table>