**School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BEDS Code: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**

**Fed ID Number: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**

# FINAL EXPENDITURE SUMMARY

7/1/18 – 6/30/19

**Expense Category**: **Amount**:

Teacher Tuition or Test Expenses $ \_\_\_\_\_\_\_\_\_\_\_

## CHIEF ADMINISTRATOR’S CERTIFICATION

I hereby certify that all expenditures reported herein are directly attributable to this project and have been made in accordance with all applicable Federal and State laws and regulations, that these monies were disbursed as supplemental compensation to teachers and that these monies were not used to supplant teacher compensation received from other revenue sources.

 **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 August 1, 2019 to the attention of Sheila Costa at the New York State Education Department, STAC & Medicaid Unit, Room 504 EB, 89 Washington Avenue, Albany, NY 12234. Replications will not be accepted.**

|  |  |
| --- | --- |
| **APPROVAL:** | **FOR SED USE ONLY** |
| **Approved By:****Name:****Date:** | Fiscal Year: | Amount Expended: | Final Payment: |
| Voucher Number: | First Payment: |
| Log | Approved | MIR |

**School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BEDS Code: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**

**Fed ID Number: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**

# FINAL EXPENDITURE SUMMARY

Teacher Summary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Teacher Name | Social Security Number | Grant Related Expenditure | Is This Teacher Now Appropriately Certified? Y/N | If not, what do they need? |
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