Huntington Community First Aid Squad
Course / Seminar Reimbursement Request

Member Name: _____ Signature: _____ Number: _____
Date: _____

Type of Course (check one)

American Red Cross, Responding To Emergencies	☐	American Red Cross, CPR BLS	☐
American Heart Association CPR HCP	☐	NYS Certified First Responder Full Course	☐
EMT Full Course	☐	NYS CFR, EMT-B, EMT-CC, EMT-P Refresher	☐
EMT-CC Full Course	☐	***Other Course (write in name below)***	☐
EMT-P Full Course *needs Board Approval	☐		☐
	☐	***Other Seminar (write in box below)***	☐

Course/Seminar/Registration Fees or Additional Fees (if any): Describe:

	$0.00
	$0.00

Text Books: (ie. Brady, Mosby, Caroline) TITLE	**Price**
	$0.00
	$0.00

Mileage: ***(there is no mileage reimbursement for any course/seminar held at HCFAS)***

Course/Seminar Location?	Did you car pool with any other members of HCFAS - ☐ Yes: Name ☐No	
How many classes did you attend?	How may did you drive to?	
What is the round trip distance from your home/HCFAS to the course site?	0.00	Total Course Miles. 0
If you were required to do off-site observation (ER, Medical Control, etc.) please indicate what was required and how many miles(round trip) you drove to get there (list by day on back):	Total Other Miles	

	Total for Course/Seminar/Registration Fees or Additional Fees						$0.00
						Total for Text Books	$0.00
	Total Course	.55/mile	$0.00	Total Other	.55/mile	$0.00	$0.00
	Other Expenses *(please list):*						$0.00
						Total Reimbursement Request	$0.00

By signing this form you are certifying to the best of your knowledge and belief that this course / seminar reimbursement request to the Huntington Community First Aid Squad (HCFAS) is true and correct. I also certify that no other party(s) has reimbursed me or will reimburse me in whole or in part for any items detailed on the request.

I acknowledge that HCFAS reimbursement is last dollar reimbursement. I further acknowledge that monies received or to be received from other sources including forgivable loan agreements etc. must be deducted prior to requesting HCFAS reimbursement and I agree that if I receive reimbursement in whole or in part from any other source after HCFAS has begun to reimburse me, I will notify HCFAS, share that reimbursement with HCFAS in proportion to the reimbursement that HCFAS has given me and reduce, pro rata, my reimbursement going forward. I affirm the foregoing statements under penalty of perjury.

Approvals:

Date: _____ Date: _____

Second Deputy Treasurer

Place this form, with a copy of your Certification/Proof of attendance and original paid receipts in the Second Deputy's Mailbox.

HCFAS Form # 154 (07/08/2010)