Western Oregon University
The Research Institute

# [L-12] First Aid/CPR Training and Substitute Care Reimbursement and Mileage Stipend

For Licensed Family Child Care Providers

**Who is eligible?** Individuals that hold the title of "Provider" in a Registered Family or Certified Family Child Care setting.

**Requirements for payments:**

1. Training must be uploaded to the Oregon Registry Online (ORO).
2. Provider must be linked to the facility in ORO and listed as "provider".
3. Reimbursement for training will be up to what the local Child Care Resource and Referral Agency Charges.
4. Reimbursement for substitute care will be for the actual cost of substitute care and must not exceed $80 for one half day or $160 for a full day.
5. WOU Substitute W-9 with information verifiable with IRS.

**Do you provide childcare to infants or toddlers (ages 0-3)? ☐ Yes ☐ No**

_____ _____

Program/Provider Name Date

_____ _____

Program Provider # Phone #

| Date of Training | Training Title | | | Amount |
|---|---|---|---|---|
| | | | | |
| **Substitute Care Reimbursement and Mileage Stipend** | | | | **Amount** |
| **Substitute Care** (for training taken during normal business hours) ☐ Half Day ☐ Full Day | | | | |
| **Address of Childcare setting:** | **Address of Training location:** | **Miles Traveled (Program to Training):** | **GSA Rate** | **Amount** |
| | | | **$0.725** | |

First Aid/CPR classes are offered free through local Child Care Resource and Referral (CCR&R) agencies. Please share why you chose to take this training instead. This information will help inform our system practices. _____

_____

**Payment Information: (Must match WOU Substitute W-9).**

_____ _____

Name of business/Individual requesting payment Street Address

_____

City, State, Zip

By signing I hereby affirm that if I am requesting reimbursement for substitute care and mileage stipends, no alternative training options outside of my program's normal operating hours were reasonably accessible.

_____ _____

Participant Signature Date

**Include the following with this form:** (Note: Forms with missing information will be held for payment until it is received.)

1. **Original receipt for training session**
2. **Receipt for cost of substitute care paid to substitute**
3. **WOU Substitute W-9**

**Submit Forms at Secure Portal:** wou.edu/tri/forms
**or**
**Mail Forms To:**
TRI at Western Oregon University
345 Monmouth Ave N
Monmouth, OR 97361

Questions: 503-838-8008, tripayments@wou.edu
Rev. 04/026

| For Office Use Only |
| --- |
| Amount:<br>Invoice#:<br>Index #:<br>Account Code:<br>Approved by: |