



The Ohio Staff Council Of Higher Education

Mission Statement: To serve as a collaborative body that fosters positive staff relations between institutions of higher education and state and local administrations.

2019-20 Quarterly Meeting Reimbursement Form (\$300 max)

Institution Primary Representative:

Name (Please print or type): _____

Institution: _____

Address: _____

City: _____ State: _____ Zip: _____ - _____

Telephone: _____ Email: _____

Reimbursement check made payable to: _____

Expenses (Please Enclose Receipts):

Team Building Activities \$ _____

Professional Development Speaker(s) \$ _____

Meals \$ _____

Facility Accommodation \$ _____

Miscellaneous (Please list) \$ _____

_____ \$ _____

_____ \$ _____

Total Expenses Accrued By Institution \$ _____

Total Amount Requested By Institution \$ _____

REQUEST FOR WAIVER APPROVAL (if over OSCE's budgeted amt.)

REQUEST FOR PAYMENT

Request for approval of payment should be mailed to:

Columbus State Community College

c/o: Michael Hicks

550 E. Spring Street

Columbus, OH 43215

Phone: (614) 287-2883 Fax: (614) 287-6026

Email: mhicks25@csc.edu

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For OSCE Fiscal Agent Use Only (To be sent to Treasurer)

Date Request Received ____/____/____

Date Payment Sent To Hosting Institution ____/____/____

Total Amt. Of Conference: \$ _____

Quarterly Meeting: Fall Winter Spring

Amt. Requested: \$ _____

Amt. Approved: \$ _____ Amt. Denied: \$ _____