THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF CHILD ACCOUNTING
Compensatory Education
440 North Broad Street – 3RD Floor
Philadelphia, Pennsylvania 19130

TELEPHONE (215) 400-4170 **FAX (215) 400-4581**

Parent Reimbursement for Compensatory Education

Date: __________

Item Description: ____

Amount: $________________________

Name of Student: ____

Student Date of Birth: ________________

Name of Parent: ____

Phone#:____

Email:____

Mailing Address: ____

City:________________, State:________ Zip:___________

Please remit payment to in the amount of $______________________

By signing this document, I acknowledge that the above services have been rendered. I also understand that the School District of Philadelphia agrees that the compensatory education hours are intended to be used to provide services and programming as stipulated by the student's settlement agreement. If the above services are not within these guidelines, payments for the services may be denied. It is the responsibility of the parent/guardian to keep an accounting of money spent from the funds outlined in the compensatory education settlement agreement.

Parent's Signature____Date:____________

(For office use only}