# [L-11] First Aid/CPR Training Reimbursement

## For Aide 1, Assistant Program Leaders, and Assistant 1 Staff/Providers

**Who is eligible?** Aide 1 or Assistant Program Leaders staff working at Certified Centers or Assistant 1 staff working at Certified Family Child Care facilities.

**Requirements for reimbursement:**
1. Training must be uploaded to the Oregon Registry Online (ORO).
2. Employee must have Aide 1, Assistant Program Leader, or Assistant 1 title and be linked to the facility in ORO.
3. WOU Substitute W-9 with information verifiable with IRS.
4. Reimbursement request must be submitted within 3 months of training date.

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

_____          _____
Program/Provider Name                                                         Date

_____          ( ____ ) _____
Program License #                                                        Phone #

**Name/s of Aide 1/Assistant Program Leader/Assistant 1s for whom reimbursement is being requested:**
**(Attach additional pages if needed.)**

| #1 | | #6 | |
|----|----|----|----|
| #2 | | #7 | |
| #3 | | #8 | |
| #4 | | #9 | |
| #5 | | #10 | |

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

_____          _____
Name of business/individual requesting reimbursement          Street Address

_____
City                                   State          Zip

_____          _____
Signature                                                                Date

**Include the following with this form:**
1. **Original receipt/s for each individual**
2. **WOU Substitute W-9**

Note: Forms with missing information will be held for payment until information is received.

**Mail Forms To:**
Western Oregon University
TRI/Central Coordination of CCR&R
345 N Monmouth Ave Monmouth, OR  97361

Questions: 503-838-8008, tripayments@wou.edu

| For Business Use Only |
|---|
| Amount: |
| Invoice #: |
| Index #: |
| Account Code: |
| Approved by: |

**Western Oregon**
UNIVERSITY
The Research Institute

# Demographic Questionnaire

**You may choose not to provide demographic information. It will not affect the status of your reimbursement/stipend. Note: For First Aid/CPR Reimbursement for Aide 1/Assistant 1 please have the Aide 1/Assistant 1 complete the Questionnaire.**

Program/Provider Name

Date

Program License #

( ) _____
Phone #

**Decline to answer questionnaire**

1. **Which of the following describes your racial or ethnic identity? Please check All that apply.**

| ☐ Native American | ☐ Native Hawaiian or Pacific Islander |
|---|---|
| ☐ American Indian<br>☐ Alaska Native<br>☐ Canadian Inuit, Metis<br>☐ Indigenous Mexican<br>☐ Central American<br>☐ South American<br>☐ Other Native American (please list) _____ | ☐ Guamanian or Chamorro<br>☐ Micronesian<br>☐ Native Hawaiian<br>☐ Samoan<br>☐ Tongan<br>☐ Other Pacific Islander (please list) _____ |
| ☐ Hispanic of Latinx | ☐ Black or African American |
| ☐ Hispanic or Latinx - Central American<br>☐ Hispanic or Latinx - Mexican<br>☐ Hispanic or Latinx - South American<br>☐ Other Hispanic or Latinx (please list) _____ | ☐ African American<br>☐ African (Black)<br>☐ Caribbean (Black)<br>☐ Other Black (please list) _____ |
| ☐ Asian | ☐ Middle Eastern |
| ☐ Asian Indian<br>☐ Chinese<br>☐ Filipino/a<br>☐ Hmong<br>☐ Japanese<br>☐ Korean<br>☐ Laotian<br>☐ South Asian<br>☐ Vietnamese<br>☐ Other Asian (please list) _____ | ☐ Northern African<br>☐ Middle Eastern<br>☐ Other (please list) _____ |
| | ☐ White |
| | ☐ Eastern European<br>☐ Slavic<br>☐ Western European<br>☐ Other White (please list) _____ |

2. **What is your preferred language? List below.**

_____