

[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.

Name of business/individual requesting reimbursement Street Address City State Toliginal receipt/s for each individual Coriginal receipt/s for each individual 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	Program/Provider Name		Date		
Name/s of Aide 1/Assistant Program Leader/Assistant 1s for whom reimbursement is being requested: (Attach additional pages if needed.) #1 #6 #7 #8 #9 #9 #10 #9 #10 #10 #10 #10 #			()		
#1 #6 #7 #7 #8 #8 #8 #9 #10 #10 #10 #10 #10 #10 #10 #10 #10 #10	Name/s of Aide 1/Assistant Program Leader/Assistant	1s for whom reim		uested:	
#3 #8 #9 #10 Payment Information: (Must match WOU Substitute W-9.) Name of business/individual requesting reimbursement Street Address City State Zip 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 #8 #9 #10 Date For Business Use Only Amount: Invoice #: Invoice #: Index #:		#6			
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Questions: 503-838-8008, tripayments@wou.edu Approved by:	Signature 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 path of the path	City Date Date For B Amou	mation is received. usiness Use Only unt: ce #:	Zip	



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			☐ Guamanian or Chamorro		
	☐ Alaska Native			☐Micronesian		
	\square Canadian Inuit, Metis			☐ Native Hawaiian		
	☐Indigenous Mexican			□Samoan		
	☐ Central American			□Tongan		
	☐ South American			☐ Other Pacific Islander (please list)		
	☐ Other Native American (please list)					
	Hispanic of Latinx			Black or African American		
	☐ Hispanic or Latinx - Central American			☐African American		
	☐ Hispanic or Latinx - Mexican			☐ African (Black)		
	\square Hispanic or Latinx - South American			☐ Caribbean (Black)		
	\square Other Hispanic or Latinx (please list)			☐ Other Black (please list)		
						
	Asian			Middle Eastern		
	☐ Asian Indian —			☐ Northern African		
	☐ Chinese			☐ Middle Eastern		
	□ Filipino/a			Other (please list)		
	☐Hmong					
	□Japanese			And to		
	□Korean			White		
	□Laotian			□ Eastern European		
	☐ South Asian			□Slavic		
	□ Vietnamese			☐ Western European		
	\square Other Asian (please list)			\square Other White (please list)		
2. What is your preferred language? List below.						