CREDENTIAL REIMBURSEMENT REQUEST

JSND/WORKFORCE PROGRAMS

SFN 61202 (3-17)

This form should be completed by the entity that paid for the test and is requesting reimbursement.

Business/Individual			
Address	City	State	ZIP Code
Telephone Number	Reimbursement Request Date		

Information on individuals who received the industry recognized credential or license.

Name	Occupation
Name	Occupation
Name	Occupation
Name	Occupation

If requesting reimbursement for more than four individuals, attach an additional sheet.

Organization that administered the test
Cost of credential/license test

The following supporting documentation must be included with this request:

- A receipt showing the amount of payment and the type of credential/license received
- A completed W9 form if the calendar year reimbursement request(s) will exceed $600

Submit documents to:

Workforce Programs
Job Service North Dakota
PO Box 5507
Bismarck ND 58506-5507
FAX: 701-328-4894
jsnjt@nd.gov

I certify that to the best of my knowledge and belief, this information is correct and complete. Attached documentation are actual expenses and substantiate the amount of reimbursement.

Signature	Date