Health Services
LOS ANGELES COUNTY

Los Angeles County – Department of Health Services

NATIONAL SPECIALTY AND BOARD CERTIFICATION REIMBURSEMENT

C L A I M

INCOMPLETE OR ILLEGIBLE APPLICATION FORMS WILL NOT BE PROCESSED
Please submit proof of payment along with proof of successful acquisition of the certification.

SECTION I. EMPLOYEE INFORMATION			
Last Name		First Name	
Employee No.			
Employee Mailing Address			
	City:	State:	Zip:
Work Facility Name			

SECTION II. CERTIFICATION INFORMATION (PART A)			
Title of Certification			
Date Certified (MM\DD\YY)			
Please Verify	☐ Proof of certification is attached ☐ Itemized receipt is attached	Fee Paid	$

IF APPLICABLE

SECTION II. REIMBURSEMENT INFORMATION (PART B: EXAMINATION)				
Title of Corresponding Exam				
Date of Exam		☐ Receipt for Exam is Attached	Fee Paid	$

IF APPLICABLE

SECTION II. REIMBURSEMENT INFORMATION (PART C: TRAINING/ COURSE)				
Title of Corresponding Training /Course				
Date Completed		☐ Receipt for Training is Attached	Fee Paid	$

Total Fees	$

I request reimbursement for the national specialty and board certification fees paid as listed above. Proof of payment and proof of successful completion are attached. I understand that I am entitled to payment of only one certification during the life of the contract.			
Employee Signature		Date	

SECTION III. TO BE COMPLETED BY FACILITY NURSE RECRUITMENT OFFICE OR NURSING ADMINISTRATION			
FACILITY NURSE RECRUITMENT OFFICE OR NURSING ADMINISTRATION OFFICE DESIGNEE USE ONLY			
Reviewed and approved by Facility Nurse Recruitment Office or Nursing Administration Office Designee: ☐ YES ☐ NO			
Signature		Date	
Print Name		Payroll Title	

AMOUNT TO BE REIMBURSED	$