Color Vision Test
Reimbursement Policy and Request Form

Select the Reimbursement Form on Page 2, if you are seeking to reflect in a classification on any of the rosters that require a color vision test ("Test"); you may be eligible to be reimbursed for fees incurred to take the Test.

Select the Reimbursement Form on Page 3, if you have previously submitted a color vision test for a classification requiring a color vision test ("Test"); you may be exempt from the 60-day rule and eligible for reimbursement for obtaining a Test after March 15, 2020, due to COVID-19 and Contract Services' temporary suspension of all in-person services, including the administration of the Test.

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In order to be reimbursed, you must provide Contract Services with sufficient documentation to substantiate your eligibility for reimbursement and demonstrate you incurred the fee for which you are seeking reimbursement. Such documentation must be submitted to Contract Services within 60 days of when you incurred the fees for the Test.

Please submit this completed "Reimbursement Policy and Request Form," along with the following items:

1. Copy of passing color vision report from an authorized person
2. Copy of the receipt(s), invoice(s) and/or statement reflecting fee
3. Proof of payment (copy of your credit card receipt, credit card statement, or the front and back of the canceled check)

This program is an "accountable plan" as provided in Internal Revenue Code Section 62(a)(2)(A) and the Treasury Regulations promulgated thereunder. To receive reimbursement for your eligible employment-related expenses, you must meet several requirements. You will be required to return to Contract Services within a reasonable time any excess reimbursement that is made to you in the event of any inadvertent overpayment.

Local/Classification:			
Local:	Job Classification:		
Personal & Contact Information:			
First Name:		Middle Name:	
Last Name:		Suffix *(Jr., Sr., II, etc.)*:	Last 4 of SSN:
Mailing Address:			Unit # *(Apt., Ste., etc.)*:
City:	State:		ZIP Code:
Country *(if not United States)*:			
Cell Phone:		Home Phone:	
Email Address:			

I have read and understood the reimbursement policy and hereby agree to abide by all the terms and conditions contained therein.

Signature: _____ **Date:** _____

You may submit your request for reimbursement with documentation by email to roster@csatf.org, mail, or fax.
Please allow 4-6 weeks for processing your reimbursement request.

Contract Services — Attention: Reimbursements
2710 Winona Avenue
Burbank, CA 91504

Phone Number: 818.565.0550 ext. 2120
Fax Number: 818.565.0535

Staff *(for office use only)*:		
Receipt Amount: $	Reimbursement Amount: $	Code:
Approved By *(Initials & Date)*:	Supervisor *(Initials & Date)*:	Director *(Initials & Date)*:

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Last Name:		Suffix *(Jr., Sr., II, etc.)*:	Last 4 of SSN:
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City:	State:		ZIP Code:
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