

4PM AND AFTER SCHOOL BUS TRANSPORTATION REIMBURSEMENT INVOICE

School OPT Code:
 School Name:
 School Address:
 City/State/Zip:
 Telephone Number:
 E-Mail Address:
 Fax Number:
 Contact Person:.

Vendor Code:
 Vendor Invoice No
 Vendor Invoice Date

MM/DD/YYYY

Month/Year of Service:	MM/YYYY
Monday - Friday School Days in Month:	
No. of Eligible Students Days of the Month:	
Daily Reimbursement Rate:	\$13
Total Invoice Amount:	\$0.00

BILLED TO:
 NYC Department of Education
 Office of Pupil Transportation - Finance
 44-36 Vernon Boulevard, Room # 403
 Long Island City, NY 11101
 Email: OPTAFTER4@schools.nyc.gov

LICENSED TRANSPORTATION PROVIDER COMPANY	ADDRESS	CITY/STATE/ZIP	CONTACT	NYS DOT ID #	# OF ELIGIBLE STUDENTS

Authorized School Signature: _____ Date: _____
 By signing and emailing the above I acknowledge that we are billing for eligible students approved in the NPSIS (Non- Public School Information System).

Print Name: _____ Title: _____

FOR DEPARTMENT OF EDUCATION ONLY			
DOE Reviewer Signature: _____	Date: _____		
Actual Public School Calendar Days: _____	Adjustments: _____		
# of Eligible Students: _____	Total Reimbursed: _____		
Comments: _____			
			Form: A4-2 4/27/2018