OUT-OF-STATE TRAVEL
FY21

Instructions:
1. Save this form on cooperative or district letterhead and attach detailed information, such as the conference/program announcement, registration form, and/or brochure, verifying fees and dates. Any additional documentation available to support the anticipated cost of the travel should also be attached.
2. Email the completed form and supporting documentation to your ISBE grant coordinator: Kimberly Beachy (kbeachy@isbe.net), Josh Green (jgreen@isbe.net) Mandi Richards (marichar@isbe.net) or Todd Williams (todwilli@isbe.net).
3. Travel will only be approved for district/cooperative employees when the request is submitted at least one week prior to the date(s) of travel.
4. This form is only required when the travel is in excess of 50 miles from the Illinois border.

NAME OF TRAVELER__________________________________________________________

NAME OF COOP/DIST: _________________________________________________________

RCDT #:______________________________________________________________________

POSITION: ___________________________________________________________________

☐ Special Education Provider

☐ General Education Provider: How will conference benefit students with disabilities?

______________________________________________________________________________

______________________________________________________________________________

DATES OF TRAVEL: ___________________________________________________________

FUNDING SOURCE: Part B Flow-Through ____________ Part B Preschool ____________

NAME OF CONFERENCE: ______________________________________________________

LOCATION: __________________________________________________________________

PURPOSE: __________________________________________________________________

ANTICIPATED COSTS:

TRANSPORTATION: ___________________________________________________________

LODGING: __________________________________________________________________

MEALS: ____________________________________________________________________

CONFERENCE REGISTRATION FEE: ____________________________________________

SUBSTITUTES: __________________________________________________________________

TOTAL GRANT FUNDS REQUESTED: ____________________________________________

REQUIRED SIGNATURES:

DIRECTOR OF SPECIAL EDUCATION: ____________________________________________

PROGRAM DIRECTOR: ________________________________________________________

ISBE GRANT COORDINATOR: ________________________________________________