



PFSO TEACHER/STAFF
ASSISTANCE PROGRAM REQUEST FORM

NAME: _____

SUBJECT/DEPARTMENT: _____

COMMITTEE: (IF APPLICABLE) _____

DATE OF REQUEST: _____

(NOTE THAT PFSO BOARD WILL NEED 30 DAYS TO CONSIDER REQUESTS)

REQUEST AMOUNT: _____

EMAIL & CONTACT INFO: _____

REASON FOR REQUEST:

GIVE US A GENERAL DISCRPTION OF WHAT FUNDS WOULD BE USED FOR.

PRESIDENT SIGNATURE: _____

DATE APPROVED: _____

TREASURER SIGNATURE: _____

*ALL REQUEST WILL BE REVIEWED AT PFSO MEETINGS. APPLICANTS WILL BE INFORMED, REGARDLESS OF APPROVAL OR DENIAL WITHIN 30 DAYS OF REQUEST. WE HOPE TO MEET AS MANY REQUEST AS POSSIBLE.