WASHINGTON STATE
Office of Financial Management

Instructions For Completing the Employee Travel and Expense Reimbursement Registration / Change Form

The form should be used when seeking travel and expense reimbursement:

- Register for a new Washington Statewide Supplier ID.
- Change an existing Supplier ID record. If changing an existing record, the Supplier Number is required.

Note:
If writing instead of typing, please PRINT clearly in blue or black ink only. Forms will not be accepted if they have whiteout, have been crossed off, or have been written over.

Part A – Identification Details:

- Agency Name – Abbreviation of the agency you are affiliated with
- Employee Name – Employee's First and Last Name
- Mailing Address – Indicate the address you wish to receive remittance and/or correspondence.
- Telephone Number – The telephone number of the employee.
- Email Address – The email address provided will be used as the primary contact method. Your Supplier ID will be emailed to this address.
- Employee Number – EE + Employee's personnel number

Part B – Payment Option:

- Check the box indicating your preferred method of payment.

Part C – Direct Deposit Information and Signature:

- If you checked Direct Deposit in Part B, fill out all fields in Part C.
- Your bank's name and phone number are both required.
- If the Payment type is left blank, we will default to corporate/business payment.
- If the Account type is left blank, we will default to checking account.

Important: It will take three to five business days for your direct deposit to activate.

Changes to an Existing Employee / Supplier Record:
To make changes to an existing employee / supplier registration, complete this form and select "Change an Existing Record". You MUST enter the Supplier Number of the record you are changing.

Signature Block:
Please sign with a pen (a "wet signature"). Electronic, inserted or stamped signatures will not be accepted. This form is not considered valid unless it is signed.

Submitting the Employee Travel and Expense Reimbursement Registration Form:
Please PRINT and SIGN the completed form then

- SCAN to PDF format and EMAIL to: supplierforms@ofm.wa.gov
- FAX to: (360) 664-3363
- MAIL to: Statewide Registration, PO Box 41450, Olympia, WA 98504-1450

For questions about the form, please contact the Statewide Registration Desk at (360) 407-8180. For any other questions, please contact the agency you are expecting payment from.

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PLEASE DO NOT STAPLE

Employee Travel and Expense Reimbursement Registration Form

Select one: ☐ New Registration ☐ Change an Existing Record (please enter Supplier Number below)

Supplier Number: SPL

PART A – Employee Identification Details

Agency Restriction (enter agency abbreviation): _____

Employee Name: _____

Telephone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Email Address: _____

Employee ID Number: _____

PART B: Select Payment Option

☐ Direct Deposit to bank (recommended).

☐ Check in US mail (terminates any previous banking information on file).

PART C: For Direct Deposit, complete all fields below then print and sign

In addition to providing your banking information on this form, you may also attach a voided check.

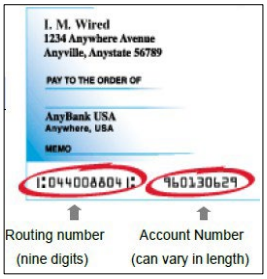
Payment Type: ☐ PPD (Personal)

Financial Institution Name – must be a US institution: _____

Account Type: ☐ Checking ☐ Savings

Routing number – see example at right: _____

Account Number – see example at right: _____



Authorization for Direct Deposit

I hereby authorized and request the Office of Financial Management (OFM) and the Office of the State Treasurer (OST) to initiate credit entries for payee payments to the account indicated above, and the financial institution named above is authorized to credit such account. I agree to abide by the National Automated Clearing House Association (NACHA) rules regarding these entries. Pursuant to the NACHA rules, OFM and OST may initiate a reversing entry to recall a duplicate or erroneous entry that they previously initiated. I understand that if a reversal action is required, OFM will notify this office of the error and the reason for the reversal. This authority will continue until such a time OFM and OST have a reasonable opportunity to act upon written request to terminate or change the direct deposit service initiated herein.

_____ _____

SIGNATURE OF EMPLOYEE (No electronic, stamped or inserted signatures) Date: This form is valid for 90 days