OFFICE OF THE ATTORNEY GENERAL
CRIME STOPPERS TRUST FUND

MONTHLY STATEMENT OF SALARY/BENEFITS

AGENCY NAME:				REIMBURSEMENT PERIOD:	
GRANT NUMBER:		PAY PERIOD:			

EMPLOYEE'S NAME	TOTAL CS HOURS	Ending Date of Pay Period	EMPLOYEE'S NET CHECK AMOUNT	EMPLOYEE'S TAXES (FICA, Medicare & Withholding)	EMPLOYEE'S DEDUCTIONS Life, Health & Dental Ins., Def. Comp.	GROSS PAYROLL	EMPLOYER PAID BENEFITS FICA,Medicare,Life,Health,Dental,LTD Pension,WC,etc.	TOTAL AMOUNT REQUESTED TO BE REIMBURSED
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
			TOTAL:	TOTAL:	TOTAL:	TOTAL:	TOTAL:	TOTAL:
TOTAL SALARY/BENEFITS:			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Authorized Signature of Grantee **Typed Name of Authorized Signature** **Date**

NOTE: This form must be completed each month by all Agencies with Salaried Employees requesting salary reimbursement and must be submitted with the Reimbursement Request/Expenditure Report.

A copy must also be kept on file at the Office of the Grantee along with supporting documentation and made available upon request by the Office of the Attorney General or it's representative.

CSA-2.1C - Monthly Statement of Salary/Benefits - Revised (08/2015)
Rule 2A-9.006(7)(f), Florida Administrative Code