

University of Florida

Wireless Communication Service Reimbursement Request

(Personal Device – Monthly Service Reimbursement)

Section 1: Request Type

Initiate Reimbursement Modify Existing Reimbursement End Reimbursement

Section 2: Employee Information

Employee Name: _____

UFID: _____

Job Title: _____

Department ID: _____

Section 3: Department and Funding Information

Department ID: _____

Chartfield: _____

Reimbursement expenditures will be charged to the chartfield provided above in accordance with university financial procedures.

Section 4: Reimbursement Details

Monthly Reimbursement Amount: _____

Reimbursement Start Date: _____

Reimbursement End Date: _____

Maximum allowable reimbursement is \$50.00 per month. The reimbursement end date may not exceed one (1) year from the reimbursement start date. It is the responsibility of the UNIT to ensure reimbursement is ended when the employee is no longer eligible.

Section 5: Business Justification

Provide a brief justification describing why the employee's role requires routine business use of a personal wireless communication device.

(Examples: on-call duties, emergency response, off-site or field-based responsibilities, after-hours responsibilities)

Section 6: Eligibility Attestation

By checking the boxes below and signing this form, the department affirms that:

- This position requires routine business use of a personal wireless communication device.
- This employee is not assigned a University owned wireless communication device.

Section 7: Employee Acknowledgement

By checking the boxes below and signing this form, the employee acknowledges that:

- I am not receiving wireless device reimbursement from another UF department or affiliated activity.
- I understand reimbursement is capped at \$50 per month and may be reviewed, adjusted, or discontinued.

Section 8: Certifications and Approvals

- I certify that the information provided on this form is complete and accurate. I understand that misrepresentation may result in reimbursement revocation and/or disciplinary action.

Employee Signature: _____

Date: _____

- By signing below, I certify on behalf of the department that the eligibility criteria and attestations in Sections 5–7 have been reviewed and are accurate.

Supervisor / Dept Head Name: _____

Title: _____

Supervisor Signature: _____

Date: _____

College or Administrative Unit Senior Finance Officer or Designee:

Date: _____

Completed forms and related documentation must be retained in accordance with university records retention and audit requirements.

Form ID: FA-FIN-WDRR Effective Date: July 1, 2026