

Richland County School District One
Student Transportation Services
.....on the go for you



TRANSPORTATION REQUEST FOR AFTER SCHOOL/SPECIAL PROGRAM

To: STS Director
(Transportation Office Servicing Your Cluster)

DATE OF REQUEST: _____

FROM: _____ SCHOOL: _____ PHONE: _____

Name of Program: _____ Point of Contact: _____

Phone # _____ After Hours Phone Number(s): _____

Number of Students Requiring Transportation Support: _____

Start Date ___/___/___ Ending Date ___/___/___

Start Time: ___:___ PM Ending Time: ___:___

Days of Operation: Mon ___ Tues ___ Wed ___ Thurs ___ Fri ___ Sat ___

Funding Account Code: _____

Brief Description of Program

Additional Coordinating Instructions

Submitted By: _____
(Name and Title)

_____ Date

Approved By: _____
(Name and Title)

_____ Date

Distribution: Transportation/White Bookkeeper/Yellow Requestor/Pink
