



Please complete this form to identify all staff to represent your agency in the School Nutrition Programs. Each individual will be provided individual access to the Ohio Department of Education Claims Reimbursement and Reporting System (CRRS). This form is to be signed by the owner, board chair, or other authorized administrator.

On behalf of _____ (NAME OF SPONSOR) (IRN NUMBER)

I hereby authorize the employee(s) below to represent this organization to the Ohio Department of Education Office for Child Nutrition, School Nutrition Programs, and to submit claims for reimbursement and other documents for the Child and School Nutrition Programs in the Claims Reimbursement and Reporting System (CRRS). The organization will immediately notify the state agency of any changes relating to authorized individuals.

Original Signature _____

Print Name _____

Print Title _____ Date _____

Authorized Individual 1

Form fields for Authorized Individual 1: SALUTATION, FIRST NAME, LAST NAME, TITLE, FOOD DISTRIBUTION PROGRAM (FDP) ACCESS (YES/NO), FACILITY PHONE, EXT, FAX, SIGNATURE, EMAIL

Authorized Individual 2

Form fields for Authorized Individual 2: SALUTATION, FIRST NAME, LAST NAME, TITLE, FOOD DISTRIBUTION PROGRAM (FDP) ACCESS (YES/NO), FACILITY PHONE, EXT, FAX, SIGNATURE, EMAIL

If the authorized individual(s) are added to CRRS due to a change in personnel, please indicate below the person(s) to inactivate in the CRRS program:

Inactivate Individual 1

Form fields for Inactivate Individual 1: SALUTATION, FIRST NAME, LAST NAME, TITLE

Inactivate Individual 2

Form fields for Inactivate Individual 2: SALUTATION, FIRST NAME, LAST NAME, TITLE