



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 18, 2015

To: All NYS BEMS Proctors
Re: Voucher Submissions Payments

To Whom It May Concern:

The New York State Office of the State Comptroller has issued a new Claim For Payment voucher, AC3253-S, which replaces the previous form, AC92. Effective as of the date of this letter, all Claims For Payment must be submitted using AC3253-S.

Exam Proctors are eligible to submit to the Bureau of EMS for payment of examinations they proctored. The BEMS Proctor’s Manual outlines payment rates and other pertinent information for Proctors.

Form AC3253-S is a fill-in-able Adobe PDF document, which can be filled out on your computer, printed, then submitted to BEMS. We encourage you to take advantage of this format instead of printing the form and then filling it out so the form is legible and accurate. Following are the instructions to fill out the form:

One examination date is allowed per voucher.

Vendor Name	Proctor’s name.
Address, City, State, Zip Code	Proctor’s official mailing address.
Vendor Identification Number	Proctor’s vendor ID number as assigned by the Office of the State Comptroller. If you have not received your vendor ID, please go to: http://www.sfs.ny.gov/ and follow the information for “Vendor Support”.
Invoice Number <i>Updated 09/18/15</i>	For most proctors: EMS-course#-Exam Date i.e.: EMS-125006-09/17/15 (if more than one course, choose one to use) For Regional Test Site proctors: EMS-RTS#-09/17/15 i.e.: EMS-RTS15-09/17/15 For On-Site Scoring proctors: EMS-OSS#-09/17/15 i.e.: EMS-OSS4-09/17/15
Exam Location	The location the exam was held where you proctored. Please supply facility name and address.
Written Exam Date	The date of the exam that you proctored.
Exam Start Time	The time the exam began.
Course Number(s)	The course number(s) you proctored the exam for.
ADA Student	If you were approved to proctor an ADA student, check this box.

Supervisor	If you were approved to be a Supervisor for this exam location, check this box.
Proctor Rate	The reimbursement rate that corresponds to your exam and location as per the Proctor's Manual.
Amount	This will automatically calculate for you.
Additional Courses	If you were approved to proctor additional courses at this exam time, select the corresponding rate.
Total	This will automatically calculate for you.
Discount %	Leave blank.
Net	This will automatically calculate for you.
Vendor's Signature	Must be signed in ink once form is printed.
Title	Title of person signing this voucher.
Date	Date of signature.
Name of Company	Leave blank.

The AC3253-S and other information can be found on our web site at: <http://www.health.ny.gov/nysdoh/ems/main.htm>. If you have questions regarding submission of vouchers, please contact our Funding Unit at (518) 402-0996 ext. 1, #4.

Sincerely,

Andrew G. Johnson, BS, AEMT-P, CIC
Deputy Director for Education and Certification
Bureau of Emergency Medical Services

State
of
New York

CLAIM FOR PAYMENT

Vendor Information

Vendor Name		Vendor Identification Number			
Address		City	State	Zip Code	
		Invoice Number			

Purchase Order No. and Date	Description of Materials/Service	Quantity	Unit	Price	Amount

Vendor Certification

I certify that the above bill is just, true and correct; that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

_____ Title
 _____ Vendor's Signature in Ink
 _____ Date _____ Name of Company

Total	
Discount %	
Net	

NYS Agency Information

Vendor Identification Number		Vendor Location ID		Vendor Address Sequence	
Voucher ID	Business Unit Name		Bus. Unit	Interest Eligible (Y/N)	Contract ID
Payment Date (MM) (DD) (YY)		Liability Date (MM) (DD) (YY)		Merch/Inv. Rec'd Date (MM) (DD) (YY)	
Withholding Class	Withholding Amount	Handling Code	Payee Amount		
Invoice Number			Invoice Date		

PeopleSoft Format Charge Lines (If Applicable)

Business Unit	Department	Program	Fund	Account
Budget Reference	Project ID	Activity	Class	Operating Unit
Product	Chartfield 1 - Accumulator	Chartfield 2 - Agency Use	Chartfield 3	Amount

Legacy Format Charge Lines (If Applicable)

Expenditures							Liquidation				
Dept	Cost Center	Var	Yr.	Object	Accum		Amount	Orig.Agency	PO/Contract	Line	F/P
					Dept.	Statewide					
Liability Date		From Date	TC	Subledger				Optional			