Print Form Reset Form

Bicycle Commuter Program Quarterly Self-Certification

Department of Human Resources
State of California

Complete this form and submit according to your department's internal claim process (CalATERS, STD 262A, or your department's travel expense claim form).

Employee Information

Name	Department

Work Email	Work Phone

Bicycle Commuting Dates

Use the drop down calendar option to enter the dates you commuted by bicycle.

Month/Year:	Month/Year:	Month/Year:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.
10.	10.	10.
11.	11.	11.

False Claims

Making a false claim to the State of California by knowingly presenting or knowingly causing to be presented an untrue statement to obtain payment or funds from the State of California is grounds for removal from participation in the program and could result in legal action, including, but not limited to, adverse action. Employees who make false claims shall reimburse the state for funds they receive for their participation in this Program.

Certification

I certify that this information is accurate and complete and that I meet the eligibility requirements to participate in the Bicycle Commuter Program.

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____