



Pre-Authorization Request

Semester: (Check one) Fall Spring Summer **Year:** _____

Name: _____ **Date:** _____

T.E.A.C.H. ID: _____

Center Name: _____

Center DVN: _____

Intended Method of Payment: (Check one)

Recipient Employer T.E.A.C.H. Other Financial Aid

Course Prefix	Course Number	Course Title	Credit Hours	College

This form is to be returned to T.E.A.C.H. MISSOURI.

Mail to: T.E.A.C.H. MISSOURI **OR** **Fax to:** 866-697-8168
 1000 Executive Parkway Dr., Ste. 103
 St. Louis, MO 63141

Do NOT turn this form into your college.

For Office Use Only

Date Request Received	Approved	Date Authorization Sent

T.E.A.C.H. MISSOURI
 1000 Executive Parkway Dr., Ste. 103 | St. Louis, MO, 63141
 800-200-9017, Ext. 607/609 | FAX 866-697-8168
www.teach-missouri.org