THIS FORM IS TO BE COMPLETED IN FULL AND SUBMITTED PRIOR TO MEETING/CONFERENCE.

DEPARTMENT OF FAMILY MEDICINE
CME/TRAVEL AUTHORIZATION

Date of Request ______________________

TRAVELER'S NAME: ______________________________ SOCIAL SECURITY # ______________________

TITLE OF TRAVELER: ____

HOME ADDRESS: ____

____

PROPOSED DATES OF TRAVEL: ____

DESTINATION: ____

PURPOSE OF TRIP: ____

____

Estimated total cost of trip: REGISTRATION ________ AIRFARE __________ HOTEL ___________

MEALS ____________ MISC EXPENSES _________________________ TOTAL COST _____________

DO NOT WRITE BELOW THIS BOX -- FOR ACCOUNTING USE ONLY

Prior Reimbursements

Date: ____________________ Amount Reimbursed ______________________

Date: ____________________ Amount Reimbursed ______________________

TOTAL _______________

Pending Reimbursments

Date: ____________________ Pending Approved Requests ______________________

Date: ____________________ Pending Approved Requests ______________________

TOTAL _______________

MAXIMUM DEPARTMENT EXPENDITURE APPROVED ____________________

FUNDS REMAINING ____________________

*****AMOUNT APPROVED THIS REQUEST***** ____________________

____
Medical Director/Supervisor

____
Kathleen Marie Duttge
Executive Officer