CMH RESIDENT/FELLOW PHYSICIAN EDUCATIONAL EXPENSE APPROVAL FORM

(*PLEASE PRINT*)

REQUEST DATE:________________________

NAME: ____________________________________ PGY:________________

PROGRAM: __________________________________ PAGER NUMBER: ________

ANTICIPATED EXPENSE FOR REIMBURSEMENT:

BOOKS: ____	$ ________
TRAVEL:____	$ ________
*NAME OF MEETING:*____	
MEETING DETAILS:______________________________________	
DATES: ____________________ *LOCATION:* ______________________	
OTHER: (PLEASE SPECIFY): _________________________________	
____	

*ESTIMATED COST: $__________________

EXPENSE TYPE:

☐ RESIDENT/FELLOW EDUCATION FUNDS $__________ ☐ SECTION FUNDS $__________

☐ PROGRAM TRAINING FUNDS $__________

☐ **I AM CURRENT WITH MY DUTY HOUR LOGS IN NEW INNOVATIONS**
(VERIFIED BY PROGRAM COORDINATOR)

SIGNATURES:

____________________________________ ____________________________________
RESIDENT/FELLOW PHYSICIAN DATE **PROGRAM COORDINATOR DATE**

____________________________________ ____________________________________
ADMINISTRATIVE DIRECTOR DATE **PROGRAM DIRECTOR DATE**

SUBMISSION IS THROUGH YOUR PROGRAM COORDINATOR