

**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 Reimbursements

Date: \_\_\_\_\_ Pending Approved Requests \_\_\_\_\_

Date: \_\_\_\_\_ Pending Approved Requests \_\_\_\_\_

TOTAL \_\_\_\_\_

MAXIMUM DEPARTMENT EXPENDITURE APPROVED \_\_\_\_\_

FUNDS REMAINING \_\_\_\_\_

**\*\*\*AMOUNT APPROVED THIS REQUEST\*\*\*** \_\_\_\_\_

\_\_\_\_\_  
Medical Director/Supervisor

\_\_\_\_\_  
Accounting Dept. Approval