

IMPERIAL COUNTY BEHAVIORAL HEALTH SERVICES

TRAVEL CONFIRMATION

Date: _____
To: _____
From: _____

CONFIRMATION:

This memo is to confirm that I traveled out of county for:

Name of training: _____
 Location: _____
 Departure Date: _____
 Return Date: _____
 (attach copy of Certificate of Attendance)

Please reimburse for the following:

Meals		\$	-	
Parking, Taxi, Shuttle		\$	-	
Airfare		\$	-	
Registration		\$	-	
Membership fees		\$	-	
Other		\$	-	
Mileage (attach copy of insurance)		\$	-	
Starting mileage	0		Ending mileage	0
(rate is \$0.655)				
Total amount to be reimburse		\$		

(attach original receipts for all items being claimed)
(Doctors Only: maximum reimbursement will not exceed the contracted amount per fiscal year)

Signature: _____	Date: _____
Deputy Director: _____	Date: _____
Director: _____	Date: _____

Note: Upon return and obtaining signatures, please forward to Purchasing

**IMPERIAL COUNTY
BEHAVIORAL HEALTH SERVICES**

CME TRAINING NOTIFICATION

Date: _____

To: Deputy Director

From: _____

Name of Training: _____

Dates: _____

Location: _____

Staff Attending:

Programs assigned to:

Required Documentation:

Flyer, Brochure, Agenda or Training Information

Deputy Director's Signautre

Director's Signature

Note: Please distribute completed form to programs impacted and payroll