Instructions: **PHYSICIANS MUST COMPLETE THE ENTIRE FORM AND HAVE APPROPRIATE AUTHORIZATION <u>AT LEAST 30 DAYS IN ADVANCE OF THE CME</u>**

<u>SUBMISION CHECKLIST:</u>

- ☐ **CME APPLICATION COMPLETE**
- ☐ **LEAVE OF ABSENCE FORM (FOR VACATION TIME IF APPLICABLE)**
- ☐ **OUT OF PROVINCE TRAVEL FORM (IF APPLICIABLE)**

PART 1: PHYSICIAN INFORMATION	
PHYSICIAN NAME:	**WORKSITE:**
MEDICAL DIRECTOR/CHIEF:	**DATE OF CME:**
PART 2: CME INFORMATION	
NATURE OF CME:	
PURPOSE OF CME:	
HOW WILL THIS CME ADVANCE YOUR PRACTICE AS A PHYSICIAN, AND ITS ADVANTAGE TO PATIENTS AND THE HEALTHCARE SYSTEM:	
ARRANGEMENTS FOR ON-CALL, PATIENT CARE WHEN ON CME:	
HOW DOES THIS TRAINING SUPPORT YOUR PROFESSIONAL DEVELOPMENT PLAN?	

LOCATION OF CME	☐ Within PEI ☐ Within Canada ☐ United States of America (please specify location:_________________________) ☐ International (please specify location:_________________________)
TOTAL HOURS	CME:
	Travel:
	Vacation:

PART 3: ESTIMATE OF CME COSTS

ITEM	AMOUNT	DESCRIPTION/DETAILS
1. REGISTRATION	$	
2. AIRFARE	$	
3. GROUND TRANSPORT (Taxi, Tolls, Bridge, Kms.)	$	
4. MEALS	$	
5. LODGING	$	
6. BOOKS, JOURNALS, EDUCATIONAL SOFTWARE OR OTHER CME MATERIALS	$	
7. TOTAL ESTIMATE	$	

PART 4: AUTHORIZATION OF CME

SITE MANAGER/ DEPT HEAD		DATE:
MEDICAL DIRECTOR		DATE:
EDMA/ CHIEF		DATE:

PART 5: OOP TRAVEL EXPENSE CLAIM (must be accompanied by competed Part 1, 2, 3 AND 4)

5 A. DETAILS OF EXPENSES INCURRED AND CLAIMED (to be completed upon return)

DATE	REGISTRATION	AIRFARE	TRANSPORT	LODGING	MEALS	INCIDENTALS	DETAILS (Include vendor name)

5 B. DETAILS OF PRIVATE VEHICLE USAGE (if applicable)

DATE	FROM	TO	KMS	C/KM	$
(Transfer total $ Costs to "Transport" under Part 5 (a) of expenses incurred and claimed:				TOTAL	$

5 C. SUMMARY OF COSTS AND AMOUNT TO BE REIMBURSED (to be completed upon return)

		ACCOUNT CODE (Service/Site/Primary/Secondary/Program)
1. REGISTRATION	$	
2. AIRFARE		
3. TRANSPORT		
4. LODGING		
5. MEALS		
6. INCIDENTALS		
7. TOTAL		
8. ADVANCED RECEIVED		
9. EXPENSES PAID BY HPEI		
10. REIMBURSEMENT FROM 3RD PARTY		
AMOUNT PAYABLE = 7-8-9-10		
to PHYSICIAN		to HEALTH PEI
$		$

I certify that the above account of travel expenses is correct in all respects and that all expenses reported were necessarily incurred on official Health PEI business.

_____________ Date

_______________________ Physician's Signature

______________ Date

_______________________ Approved by