# COMMUNITY HEALTH AND FAMILY MEDICINE

## *REQUEST FOR TRAVEL APPROVAL*

Date: _____

Traveler's Name: _____ UF ID #: _____

Position: _____ Destination (City/State): _____

**Name of Conference:** _____

**Purpose of Trip:** ☐ CME ☐ Presentation ☐ Moderator ☐ Other _____

**Funding Source:** ☐ CME Allotment ☐ Department Funded Travel ☐ Grant ☐ Other _____

Justification (Explain Benefit to State):

**Outside Employment:** ☐ YES ☐ NO Organization: _____

(If yes, make sure that you have a Disclosure of outside Activities and Financial Interests form on file with the department. These forms can be found at http://www.med.ufl.edu/busforms/. Or contact the department.)

**Registration Prepayment Needed:** ☐ YES ☐ NO Due Date: _____ (allow 4-6 wks.)

**Mode of Transportation:** ☐ Air ☐ Rail ☐ State Car ☐ Personal Car ☐ Rental Car

Departure Date: _____ Departure Time: _____ Airport Departing From: _____

Returning Date: _____ Return Time: _____ Airport Destination: _____

Airfare $ _____

Hotel: _____ day(s) Hotel Rate $

Meal: _____ day(s) Meal Rate $ 36

Registration $ _____

Rental Car: _____ day(s) Car Rate $

Mileage: _____ (miles) Mileage Rate $ 0.445

Total Estimated Cost $ 0.00

Any unusual extra expense due to changes in reservations may have to be paid by the traveler. Always coordinate reservations/changes with the Sr. Fiscal Asst in CHFM. Tel - 273-5452 F a x - 273-5213 P O Box 100237

Meals (standard rate): Breakfast $6.00, Lunch $11.00, Dinner $19.00 = $36.00

Duties will be covered by: _____

Traveler's Signature: _____

Approved by: _____
Program Director/Clinic Manager

Approved by: _____
Chair/Vice Chair

REIMBURSEMENT: Please keep all your travel receipts and submit them with your Travel reimbursement Form. Refer to CHFM Travel Procedures for additional information.