



RURAL CONTINUING MEDICAL EDUCATION REIMBURSEMENT FORM

NOTE: ONE FORM FOR EACH CLAIM REQUIRED:

Name: _____ MSP#: _____ Specialty: _____
 Address: _____ Telephone: _____
 City: _____ Cell/Hotline: _____
 Postal Code: _____ Email: _____

Name of Course \ Conference \ Meeting: _____
 Location: _____
 Dates of Event: _____
 CME Credits Obtained: _____ (Minimum of 3.5 credit hours per day required for each day reimbursed)

| | | | |
|--|----|---|------------------------|
| Registration Fee: | \$ | Receipts Required | |
| Transportation: <small>Receipts for Airfare must include destinations & costs.</small> | \$ | Receipts Required | Mode of travel: |
| Parking Fees & Taxi Fares: | \$ | Receipts Required | |
| Car Rental: | \$ | Receipts Required | Number of rental days: |
| Mileage <small>Reimbursed at \$0.50 per kilometer</small> | \$ | | Number of kilometers: |
| Accommodation/Meals: <small>\$250/day/Hotel & Meals OR Room/Board \$80/night</small> | \$ | Receipts Required/ Not Required for room/board | Number of nights: |
| Meals and Miscellaneous Sundry Expenses: <small>Maximum \$50 per day for day meetings</small> | \$ | | Number of days: |
| Overhead Private Practice Physician: <small>\$300/day - Based on Monday to Friday practice.</small> | \$ | | # days claimed: |
| All other physicians: <small>\$180/day - Based on Monday to Friday practice</small> | \$ | | # days claimed: |

| | | | |
|--|----|-------------------|--------------|
| Books, Journals, Computer Software | \$ | Receipts Required | Description: |
| Video Conferences, Instructional Audio & Videotapes, Podcasts | \$ | Receipts Required | |
| Computer Hardware including Peripheral Devices | \$ | Receipts Required | Description: |
| Electronic Equipment (DVD, Blue Ray, iPods, Voice Recorders, Digital Cameras, PDA, Smartphone) | \$ | Receipts Required | Description: |
| Network Access Fees | \$ | Receipts Required | Description: |

CLAIM TOTAL \$ _____

Amount Requested: \$ _____ Date: _____

I hereby certify that the information provided on and with this application is truthful and accurate and that I will not access another source of reimbursement for these expenses:

Physician Signature: _____ Approval: _____ Date: _____

Please return completed form with receipts to:
 Physician Compensation
 1200 Dufferin Crescent
 Nanaimo, BC V9S 2B7

| | |
|------------------------------|-------------------|
| Allocation Available: | |
| \$ _____ | (office use only) |

For enquires call Sara Murtagh @ (250) 755.7691 ext. 53106
 Or email Sara.Murtagh@viha.ca