San Mateo County Health Services
Request for Reimbursement for
Professional Dues, Fees, CME Courses, or Clinical Training Materials

(Note: Annual limit is determined by UAPD MOU - ($2,000 for FY 2004 – 2007)

Physician Name:______________________________ **Org #:**______________

Division:__________________________ **Classification:**__________________

Date of Request:_________________________ **Phone:**_________________

Description of Requested Reimbursement:____________________________________

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Amount of Reimbursement (Attach all receipts and relevant supporting materials) $__________

If CME Course, attach any relevant descriptive material:

Title of Course:____

Name of Sponsoring Organization:_______________________________

Beginning Date:_________________ **Ending Date:**______________

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Employee's Signature **Date**

Supervisor Recommendation:

☐ **Approval**
☐ **Disapproval**
Reason:______________________________________

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Supervisor's Signature **Date**

Division Director or Medical Director Recommendation:

☐ **Approval**
☐ **Disapproval**
Reason: ______________________________________

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Division Director's or Medical Director's Signature **Date**

Distribution: White: Accounting Department Yellow: Division Personnel Pink: Employee