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: __________________________________________

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: ________________

Employee's Signature Date

Supervisor Recommendation:  □ Approval
□ Disapproval
Reason: ___________________________

Supervisor’s Signature Date

Division Director or Medical Director Recommendation:  □ Approval
□ Disapproval
Reason: ___________________________

Division Director’s or Medical Director’s Signature Date

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