Continuing Medical Education Program

Honorarium & Expense Reimbursement Form

Name:____

Date(s):____

Event(s):____

Location(s):____

PLEASE MAKE CHECK PAYABLE TO:

Name: ____

Address: ____

____

____

Social Security #: ______________________ **Tax I.D. # (if applicable):** __________________

EXPENSES: (Attach original receipts for any expenses $25.00 or greater)

Honorarium __________________

Hotel __________________

Air Transportation __________________

Ground Transportation __________________

Mileage __________________

Other __________________

TOTAL __________________

Explanation of other expenses:

____

____

____

____

Your Signature: ____________________________________ **Date:** __________________

PLEASE MAIL COMPLETED FORM & RECEIPTS TO:

CME Coordinator
Medical Staff Office
PeaceHealth St. Joseph Medical Center
2901 Squalicum Parkway
Bellingham, WA 98225

Questions? Phone the CME Office at (360) 715-4104.