D.2 ONTARIO PHCNP PROGRAM RURAL & REMOTE CLINICAL PLACEMENT TRAVEL REIMBURSEMENT FORM

Applicant's Name:
Home University:
Meeting Title *(if applicable)*:
Meeting Date(s) *(if applicable)*:

Mailing Address:

COURSE: *Include course name, location and duration*

PURPOSE: *Please explain the purpose and how it directly relates to your PHCNP rural and remote travel expenses. For all mileage claims, please indicate the date of your expense and your start/end destinations (e.g. Google map).*

DETAILS:

Date	Item/Charge Details	Quantity	Total Amount ($)
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		TOTAL	$

NOTES:

- Automobile reimbursement rates are as follows: 0.55/km (per Lakehead University)
- Each claim must provide information regarding your start and your end destination
- Each claim must be supported by original itemized receipts.
- Alcohol will not be reimbursed
- Please submit claims to your local Program Administrative Assistant your university.

______________________________ _____

Claimant signature Date