



CEDARS-SINAI MEDICAL CENTER.
CSMC Department of Surgery
Resident Time-Off Authorization

Name: _____

1. Reason for Requesting Time Off:

- Presentation: I am the PRESENTING author
- Educational Trip _____
- Chief Trip
- Personal time off/Vacation starting: _____
Return date: _____

2. **Dates Away from the Medical Center:**

_____ My last day at work is (day, date): _____

3. I will travel to the meeting by (**not applicable if taking vacation**)

- Car
- Plane: Please attach a copy of your preferred flights.
- Other: _____

My presentation is on (Day, Date):

The meeting begins on (Day, Date):

The meeting Ends on (Day, Date):

I will return to work on (Day, Date):

4. Name of Resident Covering during your absence.

5. Approved: _____

Ali Salim, Program Director

IF YOU ARE PRESENTING PLEASE ATTACH A COPY OF THE MEETING SCHEDULE

CEDARS-SINAI MEDICAL CENTER

Department of Surgery Pre-Trip Expense Itemization

INSTRUCTIONS

The Department of Surgery requires each travel request for approval to be accompanied by an itemization of anticipated travel expenses.

NAME OF PERSON TRAVELING			
DATE AND LOCATION(S) OF TRIP			
PURPOSE OF TRIP			
DEPARTMENT	DEPARTMENT ACCT. NO	CONTACT PERSON:	Ext:

							Estimated Cost
Travel Fare	Air	Rail	Bus				
Lodging							
Private Automobile:	Total Miles		Rate/Mile		Insert current rate		0.00
Other Ground Transportation					in shaded box		
Parking							
Hotel							
Meals							
Registration Fees							
Phones and/or Wires							
Supplies							
Other							
Total Anticipated Expenses							0.00

CEDARS-SINAI MEDICAL CENTER
Travel Expense Reimbursement Form - Domestic

Instructions

Reference Administrative Policy ADM00151.

Attach all receipts to this form, sign and date the form. Include this form with properly approved check request. Send check request, form and receipts to Accounts Payable. Sub-total for entertainment should be coded to account 890004. Meals should be coded to account 890000. Subtotal Other should be coded to account 888000.

Employee Name	
Phone Number	
Department Name	
Department Cost Center	

Trip Location & Purpose	
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Mileage reimbursement rate \$ 0.550 **Insert current rate in the shaded box**

Call Finance at 6-8504 for current rate

	Date	Date	Date	Date	Date	Date	Date	Total in US\$
Enter first date here ▶								
Entertainment								-

Meals:								
Breakfast (including tips)								-
Lunch (including tips)								-
Dinner (including tips)								-
Sub-Total Meals	-	-	-	-	-	-	-	-

Air / Rail / and / or Bus								-
Lodging								-
Mileage (Miles driven)								-
Mileage amount	-	-	-	-	-	-	-	-
Other Ground Transportation								-
Parking								-
Registration Fees								-
Phone and/or Wires								-
Supplies								-
Other, including exchange fees - TIPS								-
Sub-Total Other	-	-	-	-	-	-	-	-

Total	-	-	-	-	-	-	-	-
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Less Travel Advance (if any)
Amount due Employee
Amount payable to Cedars-Sinai Medical Center

I hereby certify that expenses listed on this voucher were incurred by me on official business of Cedars-Sinai Medical Center or its affiliates and include only such expenses as were necessary in the conduct of this business. These expenses have not been previously claimed. Neither have they been nor will they be presented to another individual, group or organization for reimbursement.

Signature of Employee _____ **Date** _____

CEDARS-SINAI MEDICAL CENTER
Travel Expense Reimbursement Form - Foreign

Instructions

Reference Administrative Policy ADM00151.

Attach all receipts to this form, sign and date the form. Include this form with properly approved check request. Send check request, form and receipts to Accounts Payable. Sub-total for entertainment should be coded to account 890004. Meals should be coded to account 890000. Subtotal Other should be coded to account 888000.

Employee Name	
Phone Number	
Department Name	
Department Cost Center	

Trip Location & Purpose	
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	Date	Date	Date	Date	Date	Date	Date	Date	Total in US\$
Enter first date here ▶									
Daily Exchange Rate (US equivalent)									
Entertainment									-
Meals:									
Breakfast (including tips)									-
Lunch (including tips)									-
Dinner (including tips)									-
Sub-Total Meals	-	-	-	-	-	-	-	-	-
Air / Rail / and / or Bus									-
Lodging									-
Mileage (Miles Driven)									
Mileage amount									
Other Ground Transportation									-
Parking									-
Registration Fees									-
Phone and/or Wires									-
Supplies									-
Other, including exchange fees - TIPS									-
Sub-Total Other	-	-	-	-	-	-	-	-	-
Total (Foreign currency)	-	-	-	-	-	-	-	-	
Total (US currency)	-	-	-	-	-	-	-	-	-
Less Travel Advance (if any)									
Amount due Employee									
Amount payable to Cedars-Sinai Medical Center									

I hereby certify that expenses listed on this voucher were incurred by me on official business of Cedars-Sinai Medical Center or its affiliates and include only such expenses as were necessary in the conduct of this business. These expenses have not been previously claimed. Neither have they been nor will they be presented to another individual, group or organization for reimbursement.

Signature of Employee _____ **Date** _____