

RESIDENT TRAVEL FOR PROFESSIONAL ACTIVITIES POLICY

The involvement of residents in travel related to educational activities is necessary and encouraged. Because such travel can result in absences from clinical duties and also results in numerous expenses a number of conditions must be met before such travel will be supported.

Conference time must be requested as early as possible for each academic year. Priority will be given based on the date of submission. The only exception to this guideline is for residents who require conference time for the presentation of a paper at a regional or national meeting. The residents presenting a paper will receive first priority. *Residents must submit a conference request at the time an abstract is submitted.*

Residents will be allowed up to \$1500 for papers accepted for oral presentation. Additional time, funding, and poster presentations will be reviewed on a case by cases basis. The time away for conference is 5 days. Conference travel is limited to the continental United States.

Criteria for Approved Travel:

- The reason for traveling is to present the results of original investigative work conducted while at Cedars-Sinai; or for participation in educational activities approved by the Program Director.
- The traveler will be personally making the presentation of the investigative work.
- Time away from clinical duties is minimized. Travel to the away location on the date prior to the day of presentation, and return immediately following completion of the presentation.
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Authorization for Travel: Absences from clinical Duties must be approved in writing by completing a ***Travel Request Form*** and ***Pre-Travel Expense Itemization Form***. The request will be submitted in the following order:

- Program Director and Program Coordinator
- Senior resident on service
- Administrative Chief Resident

This action is necessary so that adequate coverage can be arranged for the resident's absence from clinical duties. A travel request form must be completed and signed by the three (3) above-named individuals. The completed travel request form will indicate that coverage has been arranged in anticipation of the resident's absence.

Reimbursement of Travel Expenses: Expenses will not be reimbursed *if the approval for travel was not obtained prior to the date of departure*. Only reasonable and customary expenses will be reimbursed. Allowable expenses include:

- Domestic economy class airfare (includes the United States and Canada)
- Single hotel room
- Usual and customary meeting registration fees
- Meal allowance of \$50 per day

The following expenses will not be allowed:

- Room service charges unless included with meal allowance
- Mini-bar charges
- Bar charges
- Telephone call charges
- Late registration fees
- International air travel

Reimbursement Policy

1. Resident must turn in Travel Request Form, Pre-Trip Itemization, copy of conference brochure (showing dates and location), and Travel Expense Reimbursement Form to the Program Coordinator within two weeks of travel.
2. Original receipts are required (not copies) and must be itemized. Non-itemized receipts will not be reimbursed.



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 in shaded box	0.00
Other Ground Transportation						
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 **Insert current rate in the shaded box**
 Call Finance at 6-8504 for current rate

	Date	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	-	-	-	-	-	-	-	-	-

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** _____