

**REQUEST FOR CONFERENCE TIME**



**Requests must be submitted three (3) weeks prior to the registration deadline**

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| **Employee Name:** | | | | | | | | | | |
| **Name of Conference:** | | | | | | | | | | |
| **Conference Organizers:** | | | | | | | | | | |
| **Description:** | | | | | | | | | | |
| **Date(s):** | | **Start Date:** | | | | **Time:** | | | | |
| **End Date:** | | | | **Time:** | | | | |
| **Location:** | | | | | | | | | | |
| **How will the experience enhance patient care delivery or administrative competence?** | | | | | | | | | | |
| **How will you share this experience to benefit the department?** | | | | | | | | | | |
| **Check all that apply:** | **Time Only** | | | | | | | | | |
| **Registration Fee** | | | | **Lodging** | | **Food** | | | **Air Fare** |
|  | **Taxi** | | | **Car (gas & mileage)** | | | | | **Other Travel** | |
| **Total Cost:** | **Registration Fee $****(include only the registration fee)**  **Other Estimated Expenses $****(hotel, food, etc.)** | | | | | | | | | |
| **Are CEU’s Offered:** | | | **Yes** **No** | | | | | **How Many?** | | |

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| --- | --- |
| **Employee Signature:** | **Date:** |

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| **Discussed with Clinical Director/Manager** | **Coverage Person:** |

**(Attach copies of conference materials)**



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| **Administrative Approval:** | **Date:** |