Trainer: ______________________________ (Print Name)

Circle One: MD DO PA NP CNM RN LPN RD LD IBCLC ☐ **Solo Presenter**
☐ **Non-Physician Lead**
☐ **Same Day Cancellation**

Topic(s): ☐ Breastfeeding Fundamentals ☐ Advanced Breastfeeding Support
☐ Supporting Breastfeeding in Hospital

Start Time(s): ____:____ **AM/PM** ____:____ **AM/PM** ____:____ **AM/PM**

Date, name, and location of EPIC Breastfeeding Education presentation:

______________ **at** ____

Program Date **Practice/Facility Name** **City**

Location Traveled From: ____

My round-trip mileage was __________ **miles.**

Pre-Authorized Expenses: Meal(s) ______________________
(Receipts must be attached.)
Lodging ______________________ *** Prior Approval Required**
Other ______________________

____
Trainer Signature

....

Office Use Only

Date Received: __________ Evaluations Received: ___ Yes ___ No

Honorarium Due: $ ________________ Dept-Expense #959-7340

Miles: ______________ @____ = $________________ Dept-Expense #959-7001

Pre-Authorized Expenses: $ ________________ Dept-Expense #959-____
(Receipts must be attached.)
$ ________________ Dept-Expense #959-____
$ ________________ Dept-Expense #959-____

Total Due: $ ________________

Approved by: ________________________ **Date:** __________
EPIC Director or Coordinator

Approved by: ________________________
Executive Director

Date Mailed: ___/___/___ **by** ____

Revised 6/2016