Trainer: _____ (Print Name)

Circle One: MD/DO PA NP MN RN LPN CNM RD IBCLC CLC

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

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

Location of EPIC Breastfeeding Program Presentation:

_____ **on** _____ .
Practice/Facility Name / City County Date

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 Dir. or Coordinator

Approved by: _____ Date: _____
Executive Director

Date Mailed: ___/___/___ by ____

Revised 8/3/2012