Trainer: ______________________________________ (Print Name)

Circle Credential(s):
MD DO PA NP APRN CNM RN LPN RD LD IBCLC

Select if Applicable:
☐ Solo Presenter
☐ Non-Physician Lead
☐ Same Day Cancellation

Select Topic(s) Presented: (Each topic presented is 1-hour.)
☐ Breastfeeding Fundamentals ☐ Advanced Breastfeeding Support ☐ Supporting Breastfeeding in Hospital

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

Enter date, practice name, and location of EPIC Breastfeeding Education program:

_______________ **at** ____

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

Location Traveled From: ____

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

Pre-Authorized Expenses:
(Receipts must be attached.)

Meal(s) ______________________

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 4/2017