HEALTH CARE FOR THE HOMELESS

REQUEST FOR PROFESSIONAL DEVELOPMENT

TO BE COMPLETED BY STAFF MEMBER

Employee Name: **Team:**

Name of Seminar/Course/Conference:

Location:

Date(s)		Time		TOTAL HOURS
FROM	TO	FROM	TO	
/ /	/ /	: am pm	: am pm	

Cost:

Registration _____

Travel _____

Per Diem _____

Other (Specify) _____ _____

Other Professional Development purchases: (Example - Books, Software, Subscriptions, Licensure, certification, etc.)

Name of item: _____

Cost of item: _____

_____ _____

Employee Signature **Date**

TO BE COMPLETED BY SUPERVISOR

☐ **Approved** ☐ **Not Approved**

_____ _____

Signature **Date**

[Give the completed form along with a check request and any related materials to the Director of HR]

_____ _____

HR Signature **Date**

CONFERENCE/SEMINARS BUDGET LINE

Completed By An Officer: ☐ **Approved** ☐ **Not Approved**

_____ _____

Officer Signature **Date**

Completed by President/CEO: ☐ **Approved** ☐ **Not Approved**

_____ _____

President/CEO Signature **Date**