



DOWNSTATE

HEALTH SCIENCES UNIVERSITY

Reimbursement Procedure

Fill out **Approved Absence Form** in its entirety.

Under Section III, APPROVALS, have your manager sign and date the Form.

On the **Standard Voucher Form**, fill out the 8 starred areas:

- a) Payee ID (Last 4 of your Social Security Number)
- b) Name
- c) Address
- d) City
- e) State
- f) Zip Code
- g) Signature
- h) Date

Upon completion of your class/conference, bring back the following to Nursing Education:

- a) Approved Absence Form filled out and signed by manager.
- b) Standard Voucher filled out. If you are handwriting the information, please ensure that your writing is legible.
- c) Copy of your course/class certificate of completion.
- d) Receipt of payment.
- e) Credit Card or Bank Statement showing the charge. Statement must also show your name, print out first page of statement if needed. All other information should be blacked out/redacted such as account number, balances, payment information, other purchases. Please note that this is a Finance/Accounts Payable requirement.

Once all your forms and paperwork are verified as complete, it will be signed by Nursing Education Director, Dr Karen Broomes James. It will then be brought over to Accounts Payable for final processing. Payment will be in the form of either direct deposit or physical check mailed to you and may take up to 12 – 16 weeks.



REQUEST FOR AUTHORIZED ABSENCE AND FEE REIMBURSEMENT FOR CONTINUING EDUCATION PROGRAMS/ PROFESSIONAL MEETINGS

NAME: _____ UNIT: _____ TOUR OF DUTY: _____
TITLE _____ SOCIAL SECURITY: _____

I. REQUEST FOR AUTHORIZED ABSENCE AND FEE REIMBURSEMENT FOR THE FOLLOWING EDUCATION PROGRAM
TITLE OF PROGRAM: _____

DATE(S): _____ TIME: _____ REGISTRATION FEE: _____

LOCATION: _____

II. STATEMENT ON HOW KNOWLEDGE/SKILLS GAINED FROM THIS PROGRAM WILL BE UTILIZED BY THE STAFF MEMBER IN HIS/HER WORK.

III. APPROVALS

1. FOR AUTHORIZED ABSENCE: _____ APPROVED _____ NOT APPROVED

DIVISION SUPERVISOR _____ DATE _____

REMARKS: _____

2. FOR FEE REIMBURSEMENT: _____ APPROVED _____ NOT APPROVED

DIRECTOR, INSTITUTE OF CONTINUOUS LEARNING _____ DATE _____

REMARKS: _____

INSTRUCTIONS: TO FACILITATE THE REQUISITION, APPROVAL, AND REIMBURSEMENT PROCESSES:

1. ATTACH WITH THIS REQUEST A COPY OF THE PROGRAM FLIER, BROCHURE OR ANNOUNCEMENT DESCRIBING THE PROGRAM"
2. SUBMIT THIS REQUEST AT LEAST TWO (2) WEEKS BEFORE THE SCHEDULED PROGRAM. NO REQUESTS SHALL BE CONSIDERED AFTER (30 DAYS).
3. AFTER PROGRAM COMPLETION, SUBMIT THE FOLLOWING DOCUMENTS TO THE INSTITUTE OF CONTINUOUS LEARNING (440 LENOX ROAD, SUITE 1J).
 - ORIGINAL CANCELLED CHECK OR ORIGINAL DUPLICATE OF MONEY ORDER.
 - COPY OF ATTENDANCE (VALIDATED FROM AN ORIGINAL BY INSTITUTE OF CONTINUOUS LEARNING.

State
Of
New York

SEE INSTRUCTIONS BEFORE COMPLETING

STANDARD VOUCHER

Voucher Number

① Originating Agency (limit to 30 spaces) SUNY Downstate Medical Center			Orig. Agency Code 28100		Interest Eligible (Y/N)		② P-Contract	
Payment Date (MM/DD/YY)			OSC Use Only			Liability Date (MM/DD/YY)		
③ Payee ID		Additional	Zip Code		Route	Payee Amount		MIR Date (MM/DD/YY)
④ Payee Name (limit to 30 spaces)						IRS Code		IRS Amount
Payee Name (limit to 30 spaces)						Stat Type		Statistic
Address (limit to 30 spaces)						Indicator-Dept.		
Address (limit to 30 spaces)						Indicator-Statewide		
City (Limit to 20 spaces) (Limit to 2 spaces) → NY State						⑤ Ref/Inv. No. (Limit to 20 spaces)		
Zip Code 11201						Ref/Inv. Date (MM/DD/YY)		

⑥ Purchase Order No. and Date	Description of Material/Service If items are too numerous to be incorporated into the block below, use Form AC 93 and carry total forward.	Quantity	Unit	Price	Amount

⑦ Payee Certification

I certify that the above bill is just, true and correct; that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

Payee's Signature in Ink

Date _____

Registered Nurse

Title

SUNY Downstate Health Sciences University

Name of Company

Total

Discount %

Net

FOR AGENCY USE ONLY

STATE COMPTROLLER'S PRE-AUDIT

Merchandise Received Date Page No. By	I certify that this voucher is correct and just, and payment is approved, and the goods or services rendered or furnished are for use in the performance of the official functions and duties of this agency. <div style="text-align: center;"> _____ Authorized Signature in Ink Director of Nursing Educ. </div> <div style="display: flex; justify-content: space-between;"> <div> Date _____ </div> <div> Title _____ </div> </div>	<div style="text-align: center;"> _____ Verified </div> <div style="text-align: center;"> _____ Audited </div> <div style="text-align: center;"> _____ Special Approval (as Required) </div>	<div style="text-align: center;"> CERTIFIED FOR PAYMENT OF TOTAL AMOUNT </div> <div> By _____ </div>
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[illegible]

Distribution: Original to OSC with Copy to Agency/Department and Payee

☐ Check if Continuation form is attached.