# SUNY DOWNSTATE MEDICAL CENTER
# UNIVERSITY HOSPITAL OF BROOKLYN
# INSTITUTE OF CONTINUOUS LEARNING

## 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.**

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**III.** **APPROVALS**

1. **FOR AUTHORIZED ABSENCE:** __________ **APPROVED** __________ **NOT APPROVED**

   ______________________________ ________________
   **DIVISION SUPERVISOR** **DATE**

   **REMARKS:** ______________________________________________

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2. **FOR FEE REIMBURSEMENT:** __________ **APPROVED** __________ **NOT APPROVED**

   ______________________________ ________________
   **DIRECTOR, INSTITUTE OF CONTINUOUS LEARNING** **DATE**

   **REMARKS:** ______________________________________________

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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 (SUITE 1J, 440 LENOX ROAD).
   - ORIGINAL CANCELLED CHECK OR ORIGINAL DUPLICATE OF MONEY ORDER
   - COPY OF ATTENDANCE (VALIDATED FROM AN ORIGINAL BY INSTITUTE OF CONTINUOUS LEARNING).