DOWNSTATE
HEALTH SCIENCES UNIVERSITY

BLS 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 BLS class, bring back the following to Nursing Education:

a) Approved Absence Form filled out and signed by manager
b) Standard Voucher filled out
c) Copy of your new BLS card
d) Training Center 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 8 – 12 weeks.

SUNY DOWNSTATE Medical Center

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.

_____

_____

_____

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.

AC92 (Rev. 6/94)

State Of New York

SEE INSTRUCTIONS BEFORE COMPLETING

STANDARD VOUCHER

Voucher Number

①Originating Agency (limit to 30 spaces)	Orig. Agency Code	Interest Eligible (Y/N)	②P-Contract
SUNY Downstate Medical Center	28100		

Payment Date (MM/DD/YY)	OSC Use Only	Liability Date (MM/DD/YY)

③Payee ID	Additional	Zip Code	Route	Payee Amount	MIR Date (MM/DD/YY)

④Payee Name (limit to 30 spaces)	IRS Code	IRS Amount

Payee Name (limit to 30 spaces)	Stat. Type	Statistic	Indicator-Dept.	Indicator-Statewide

Address (limit to 30 spaces)	⑤Ref/Inv. No. (Limit to 20 spaces)

Address (limit to 30 spaces)	Ref/Inv. Date (MM/DD/YY)

City (Limit to 20 spaces)	(Limit to 2 spaces)→ State	Zip Code

⑥Purchase 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

⑦Payee 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

Registered Nurse
Title

Date

SUNY Downstate Health Sciences University
Name of Company

Total	
Discount %	
Net	

FOR AGENCY USE ONLY

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.

Authorized Signature in Ink

Director of Nursing Educ.
Date Title

STATE COMPTROLLER'S PRE-AUDIT

Verified

Audited

Special Approval (as Required)

CERTIFIED FOR PAYMENT OF TOTAL AMOUNT

By

Expenditure								Liquidation			
Cost Center Code					Accum						
Dept	Cost Center Unit	Var	Yr	Object	Dept	Statewide	Amount	Orig. Agency	PO/Contract	Line	F/P
	3213940 0										

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

☐ **Check if Continuation form is attached.**